

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02256

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Glen Arm</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Glen Arm</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Northwind Road</u>		STREET ADDRESS (If rural, give location) <u>Northwind Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elmer</u> (Middle) <u>T.</u> (Last) <u>Amrein</u>	4. DATE OF DEATH	(Month) <u>Mar.</u> (Day) <u>23</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 8, 1894</u>
		9. AGE last birthday <u>57</u> yrs.	If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>John W Amrein</u>		14. MOTHER'S MAIDEN NAME <u>Annie Eicholtz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mrs. Viola Amrein, Northwind Road.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

200.2 Immediate cause

(a) Carcinoma, Lung. Metastatic

INTERVAL BETWEEN ONSET AND DEATH

3 months

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma, Metastatic 2nd Similar Vertebral

5 months

(c) Carcinoma, Removed from Axillary Gland, Right

19 46 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

1946

19b. MAJOR FINDINGS OF OPERATION

Malignancy in Right Axillary gland.

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

CITY OR TOWN

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to 23 mch, 1951, that I last saw the deceased

alive on 21 mch, 1951, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles A Reier MD 6701 York Rd Balt Md 23 mch 51

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

3/26/51

NAME OF CEMETERY OR CREMATORY

Moreland Park

LOCATION (City, town, or county)

Balt Md

(State)

DATE REC'D BY LOCAL REG.

March 24 1951

REGISTRAR'S SIGNATURE

R.W.

24. FUNERAL DIRECTOR

H. Luck

ADDRESS

5305 Hayford Rd. 14

290246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Reier
6701 York.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02257

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE North Carolina COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Tarboro	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.		STREET ADDRESS (If rural, give location) 208 W. Battle Avenue	
3. NAME OF DECEASED (First) (Middle) (Last) FRANK L. ARENS		4. DATE OF DEATH (Month) (Day) (Year) March 20 19 51	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-7-93
9. AGE last birthday 57 yrs.		10. If under 1 year Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber (Unemployed)		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME Charles Arens		13. MOTHER'S MAIDEN NAME Viola McClara	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I		15. SOCIAL SECURITY No. 237-10-0990	
16. INFORMANT AND ADDRESS Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.		17. CITIZEN OF WHAT COUNTRY? USA	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) POST-OPERATIVE PULMONARY ATELECTASIS		UNKNOWN
Antecedent cause(s) (b) MUCOUS PLUGS IN BRONCHI		UNKNOWN
(c) PULMONARY EMPHYSEMA, MODERATE, BILATERAL DILATATION RIGHT VENTRICLE		UNKNOWN
11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)		UNKNOWN
12a. DATE OF OPERATION 3-20-51	12b. MAJOR FINDINGS OF OPERATION Absence of ramus of mandible on the left	13. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
14. ACCIDENT (Specify) SUICIDE HOMICIDE	15. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	16. (CITY OR TOWN) (COUNTY) (STATE)
17. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	18. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	19. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 13, 19 51**, to **March 20, 19 51**, and that death occurred at **9:35 P.m.**, from the causes and on the date stated above.

SIGNATURE **Joseph M. Miller** (Degree or title) ADDRESS DATE SIGNED

JOSEPH M. MILLER, M. D., CHIEF, SURGICAL SERVICE, VAH, FORT HOWARD, MD. 3-21-51

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF March 22-1951	NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	LOCATION (City, town, or county) (State) North Carolina
24. FUNERAL DIRECTOR Howard Blight	ADDRESS 6009 Harford Rd., Baltimore, Md.		

SHIP TO: Carlisle Funeral Home, Tarboro, N. C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *JS*

02258

1. PLACE OF DEATH COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EDGEWATER HOSPITAL OR INSTITUTION OR STREET ADDRESS 2925 WELLS AVE.		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EDGEWATER STREET ADDRESS (If rural, give location) 2925 WELLS AVE	
3. NAME OF DECEASED (Type or Print) CORA (First) ESTELLE (Middle) ARMSTRONG (Last)	4. DATE OF DEATH MARCH 2 1951 OF DEATH MARCH 2 1951 yrs. Months Days Hours Min.	5. SEX FEMALE 6. COLOR OR RACE W 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED 8. DATE OF BIRTH JULY 21, 1868 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM S. MABBETT	14. MOTHER'S MAIDEN NAME MARGARET A. HURD	17. INFORMANT AND ADDRESS MRS. ESTHER WHITE 2925 WELLS AVE.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage. Antecedent cause(s) (b) Arterio-sclerosis - gen. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			3 days
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 1, 1951 to March 2, 1951 , that I last saw the deceased alive on March 2, 1951 , and that death occurred at 5 P m., from the causes and on the date stated above.			
SIGNATURE [Signature] (Degree or title)		ADDRESS 520 1st St. Sp 15 DATE SIGNED 3-2-51	
23. BURIAL CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 3/6/51	NAME OF CEMETERY OR CREMATORY PARK WOOD	LOCATION (City, town, or county) (State) BALTO., MD
DATE REC'D BY LOCAL REG. 3/6/51	REGISTRAR'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR JOHN F. DENNY, INC. 715 LIGHT ST. ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

221

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

BC 02259

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 16	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 3409 Mondawmin Avenue	
3. NAME OF DECEASED (Type or Print)	(First) REUBEN	(Middle) E.	(Last) BABCOCK
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 8-8-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Engineer		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Williston, Ohio
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Adelaide Carpenter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes WW I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.		12. CITIZEN OF WHAT COUNTRY? USA	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) MYOCARDIAL INFARCTION ACUTE		3-4 days
Antecedent cause(s) (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 16, 1951**, to **March 20, 1951**, that I also saw the deceasedand that death occurred at **5:00 A.M.**, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Irving Freeman **IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 3-20-51**

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial **3-22-1951** **Moreland Park Cemetery** **Baltimore, Maryland**

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

3/21/51 **G. Howard Strong** **3207 W. North Avenue**
Baltimore, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH 820

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02260

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1623 N. Durham St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Robert</u> (Last) <u>Baker</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 11 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>8/25/1894</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bartender</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert T. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Estell Kehn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW-II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clinical Record Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Coronary arteriosclerosis with Myocardial Infarctionunknown

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>3/15/51</u>	<u>Baltimore nat</u>	<u>Balta</u>	<u>Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-14-51</u>	<u>U W Hedrich</u>	<u>Bluma + Hoffman</u>	<u>1639 Broadway</u>	

750679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02261

Reg. Dist. No. *44*

1. PLACE OF DEATH— COUNTY Balto.		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE Baltimore, Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bethlehem Steel Co.,		STREET ADDRESS (If rural, give location) 924 N. Streeper St.,	
3. NAME OF DECEASED (Type or Print)	(First) Charles	(Middle) Alyn	(Last) Bates
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sept. 7 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter		10b. KIND OF BUSINESS OR INDUSTRY Heating, etc.	9. AGE last birthday 60 yrs.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Benjamin Bates.		14. MOTHER'S MAIDEN NAME Priscilla Marriott.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 216-01-6415	
17. INFORMANT Mrs. Oser, 5605 Merville Ave.		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>420.1</i> Coronary Occlusion		
(b) Antecedent cause(s) <i>94a</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>Dr. J. D. Davis</i>		ADDRESS <i>Druid Ridge Cemetery - Pikesville, Md.</i>		DATE SIGNED <i>3/12/51</i>
23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 3/15/51	NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery,	LOCATION (City, town, or county) Pikesville, Balto. Co., Md.	(State)
DATE REC'D BY LOCAL REG. 3-25-51	REGISTRAR'S SIGNATURE <i>L</i>	24. FUNERAL DIRECTOR <i>W. Vernon Lammiman</i>	ADDRESS 4611 Park Heights Av. Balto. Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

574246

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>8219 Longpoint Road</u>	
3. NAME OF DECEASED (Type or Print) <u>ALBERT</u> (First) <u>W.</u> (Middle) <u>BAYHA</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-12-90</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Body & Fender Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Wheeling, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Bayha</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hanke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>233-09-3296</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) ARTERIOSCLEROTIC HEART DISEASE

2 YEARS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) NONE

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

HISTORY OF DIABETES MELLITUS

UNKNOWN

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that VA attended the deceased from March 19, 1951, to March 27, 1951, that I last saw the deceasedYACOBXXXXXXXXXXXXXXXXXXXX and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Irving Freeman, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 3-28-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>3/28/51</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wheeling, West Virginia</u>	
DATE REC'D BY LOCAL REG. <u>3/28/51</u>		REGISTRAR'S SIGNATURE <u>Irving Freeman</u>		24. FUNERAL DIRECTOR <u>Howard Blight Funeral Home</u>		ADDRESS <u>6009 Har-</u>	
SHIP TO: <u>Fields Funeral Home, 819 Main Street, Wheeling, W. Va. 550 816</u>							

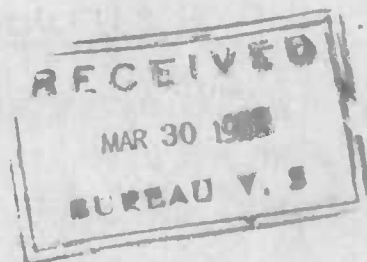
MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q,
15-30-51

COPY SENT TO ~~100~~ REGISTRAR No. DATE



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02263

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
TOWN <u>5 months</u>		TOWN <u>5 months</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Evans Avenue</u>		STREET ADDRESS (If rural give location) <u>20 Evans Avenue</u>	
3. NAME OF DECEASED (First) <u>Elizabeth</u> (Middle) <u>ANDERSON</u> (Last) <u>Beever</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>21 Dec. 1890</u>
9. AGE last birthday <u>60</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Martha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Son: Arthur Beever</u>		<u>20 Evans</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Vascular Accident</u>		<u>5 hours</u>
Antecedent cause(s) (b) <u>Arterio sclerosis - generalized</u>		<u>years</u>
(c) <u>and cerebral</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 March, 1951, to 12 March, 1951, that I last saw the deceased alive on 12 March, 1951, and that death occurred at 10:05 P m., from the causes and on the date stated above.

SIGNATURE Walter T. Kees (Degree or title) M.D. ADDRESS Cockeysville, Maryland DATE SIGNED 12 March 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Trinity</u>	LOCATION (City, town, or county) <u>Baltimore Md</u> (State)
DATE REC'D BY LOCAL REG. <u>3-19-51</u>	REGISTRAR'S SIGNATURE <u>G W Hedrich</u>	24. FUNERAL DIRECTOR <u>L. J. Luck</u>	ADDRESS <u>5305 Harford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02264

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8512 WILLOW OAK RD</u>		STREET ADDRESS (If rural give location) <u>8512 WILLOW OAK RD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>LOUIS</u> (Middle)	(Last) <u>BEIGEL</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>12</u> (Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1/30/90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CASHIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CROWN CORK & SEAL CO</u>	9. AGE last birthday <u>61</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. FATHER'S NAME <u>PAUL BEIGEL</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE DEHNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT <u>KATHERINE BEIGEL 8512 WILLOW OAK RD</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis
 Antecedent cause(s) (b) Acute Cardiac Dilatation
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
7 mos.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
 HOMICIDE INJURY
 TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1940 to Nov 12, 1951, that I last saw the deceased alive on Nov 12, 1951, and that death occurred at 7:40 PM m., from the causes and on the date stated above.
 SIGNATURE Dr. G. Geyser (Degree or title) ADDRESS 156 N. Martin Coe DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 3/16/51 NAME OF CEMETERY OR CREMATORY Mount Vernon LOCATION (City, town, or county) (State) MD
 DATE REC'D BY LOCAL REG. 3-14-51 REGISTRAR'S SIGNATURE Carl Reddick 24. FUNERAL DIRECTOR Clarence F. Hoffman ADDRESS 1677 Broadway

290716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

02265

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> <u>TOWSON</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>TOWSON 4.</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>308 YORK ROAD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> TOWN <u>4</u> STREET ADDRESS (If rural, give location) <u>308 YORK ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>HANNAH</u> <u>MARIA</u> <u>BENNETT</u>		4. DATE OF DEATH <u>MARCH</u> <u>24</u> <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT 12, 1860</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days If under 24 hr. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT MC KEOWN</u>		14. MOTHER'S MAIDEN NAME <u>JANE DOUGAL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>DAUGHTER - MRS. MARGARET ANDERSON</u>		18. <u>308 YORK RD. TOWSON, MD.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

CONGESTIVE FAILURE

Antecedent cause(s)

(b)

ARTERIOSCLEROTIC HEART DISEASE

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from MAR 23, 1951, to MAR 24, 1951, that I last saw the deceased alive on MAR 23, 1951, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Donald L. Somerville, M.D.25 W. Penna. Ave.March 24, 1951

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore 12, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3/28/51</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Augsburg Home</u>		STREET ADDRESS (If rural, give location) <u>6811 Campfield Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna</u> (First) <u>Margaret</u> (Middle) <u>Burger</u> (Last)		DATE OF DEATH <u>March</u> (Month) <u>25</u> (Day) <u>51</u> (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8/27/72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>79</u> yrs. If under 1 year <u>7</u> Months <u>2</u> Days If under 24 hrs. <u>7</u> Hours <u>2</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Conrad Wittgrebe</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Nordman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause	(a) <u>Anterior - Sclerotic Heart Disease with Arrhythmia & Embolizing</u>	<u>5 yrs.</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized Anterior Sclerosis</u>	<u>6 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to March, 1951, that I last saw the deceased alive on March - 24, 1951, and that death occurred at March - 25, 1951, from the causes and on the date stated above.

SIGNATURE Paul L. Chamberlain M.D. (Degree or title) ADDRESS 4108 L. Street Heights Ave - Balto - Md. DATE SIGNED 3/27/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/28/51</u>	NAME OF CEMETERY OR CREMATORY <u>Manuel Cemetery</u>	LOCATION (City, town, or county) <u>Balto Md</u> (State)
DATE REC'D BY LOCAL REG <u>3/27/51</u>	REGISTRAR'S SIGNATURE <u>Paul L. Chamberlain</u>	24. FUNERAL DIRECTOR <u>Paul L. Chamberlain</u>	ADDRESS <u>6067 Haystack</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Sept 28 SU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for changes
in 1 & 22 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02267

CERTIFICATE OF DEATH

Reg. Dist. No.

FILM No. G 131 MAR 22 1951

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>503 E Joppa Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ROBERT</u> <u>ALLEN</u> <u>BLACK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 10</u> <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-11-17</u>
9. AGE last birthday <u>33</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tax coordinator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black & Decker</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kenneth Black</u>		14. MOTHER'S MAIDEN NAME <u>Mabel H. Hackney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) <u>WW-2</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

340.3 Immediate cause (a) Cerebral Edema

Antecedent cause(s)

81a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Meningitis

(c)

INTERVAL BETWEEN ONSET AND DEATH

unknown

1 month

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 6, 1951, to Mar. 10, 1951, that I last saw the deceased

live on Mar. 10, 1951, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

LAWRENCE J. KNOX, M.D. VETERANS ADMINISTRATION FORT HOWARD, MD.

3-10-51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 13, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	LOCATION (City, town, or county) <u>Balto. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3-12-51</u>	REGISTRAR'S SIGNATURE <u>G W Hedrick</u>	24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> <u>North Ave. & Broadway Baltimore 13</u>		

000808

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02268

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Near Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chesaca Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanover Rd.</u>		STREET ADDRESS (If rural, give location) <u>Baltimore 6, Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frank</u>	(Middle) <u>Garfield</u>	(Last) <u>Blackburn</u>
4. DATE OF DEATH	(Month) <u>Mar.</u>	(Day) <u>23</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1900</u>
9. AGE last birthday <u>50</u> yrs.		If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Timekeeper, Road Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank P. Blackburn</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Hildebrandt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>212-03-8383</u>	
17. INFORMANT AND ADDRESS <u>Agnes M. Blackburn, Chesaca Park</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary artery Disease</u>			<u>30 min</u>
940 Antecedent cause(s) (b) <u>Obesity</u>			<u>5 yrs.</u>
(c) <u> </u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None.</u>			
19a. DATE OF OPERATION <u>None.</u>	19b. MAJOR FINDINGS OF OPERATION <u>None.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None.</u>	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>None.</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None.</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>None.</u>	HOW DID INJURY OCCUR? <u>None.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>D. D. Caples Deputy</u>		DATE SIGNED <u>3-24-51</u>	
(Degree or title)		ADDRESS <u>M.D. Reisterstown, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>	LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u> <u>3-24-51</u>
DATE REC'D BY LOCAL REG. <u>3-26-51</u>	REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>	24. FUNERAL DIRECTOR <u>Paul E. Chenoweth</u> ADDRESS <u>3615 Chestnut Ave. Baltimore, Md.</u>	

390246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 28 1961
BUREAU K. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02269 32

1. PLACE OF DEATH- COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pikesville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pikesville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 908 Windsor Rd. Sudbrook Pk.				STREET ADDRESS 908 Windsor Rd.	
3. NAME OF DECEASED (Type or Print) LIONEL		(First) M. (Middle)		(Last) BOTSFORD	
4. DATE OF DEATH Mar. 1, 1951		(Month) (Day) (Year)			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	
8. DATE OF BIRTH July 29, 1930		9. AGE last birthday 20 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Map Clerk		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Harold C. Botsford		14. MOTHER'S MAIDEN NAME Agnes C. Carlson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 214-26-5994		17. INFORMANT AND ADDRESS Mrs. Agnes C. Botsford - 908 Windsor Rd.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

196x Immediate cause

(a) **Spontaneous Collapse of Rt. Lung - Pul. Edema 3 days.**55x Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) **Fibro - Sarcoma of Spine - Generalized Metastasis 10 months.**

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION May 1950		19b. MAJOR FINDINGS OF OPERATION Fibro - Sarcoma of Spine		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct. 9th**, 19**50**, to **Mar. 1st**, 19**51**, that I last saw the deceased
alive on **Mar. 1st**, 19**51**, and that death occurred at **3:10 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 3/3/51		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) Pikesville, Md.		(State)	
DATE REC'D BY LOCAL REG. 3-2-51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR J. J. Tucker & Sons - Balto.		ADDRESS 350 736			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02270

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harrisonville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Harrisonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Ward Chapel Road</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u> (Middle) <u>Martin</u> (Last) <u>Brady</u>		(Month) <u>Mar</u> (Day) <u>ch</u> (Year) <u>1951</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct 8 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>James Farmer</u>		<u>Farmer</u>	<u>Baltimore Co Md</u>
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>John Brady</u>		<u>Elizabeth Mackenroe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
(If year, give war or dates of service)			<u>Florence M. Brady Owings Mills P.C.</u>

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <u>Tuberculosis of Lungs</u>	
Antecedent cause(s)		(b) _____	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct....., 1950, to 3/8/....., 1951, that I last saw the deceased
alive on 3/5/....., 1951, and that death occurred at 4 P..... m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4204 Ridgewood Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290116

RECEIVED
APR 3 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>(rural) Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown (rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dover Road</u>		STREET ADDRESS <u>Dover Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>EDWIN</u>	(Middle) <u>GEORGE</u>	(Last) <u>BREWER</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 28, 1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Redmond Brewer</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Anne Feaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Matilda M. Brewer, Reisterstown, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause
443X Antecedent cause(s)
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) myocarditis - chronic decompensation
(b) hypertension
(c) atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH
3 months
3 yrs
3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-1957 to 3-13-1957, that I last saw the deceased alive on 3-12-1957, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE James L. Safell M.D. ADDRESS Reisterstown Md DATE SIGNED 3/14/57

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 15, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Sater's Baptist Cemetery</u>	LOCATION (City, town, or county) <u>Lutherville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>3-15-57</u>	REGISTRAR'S SIGNATURE <u>John Redmond</u>	24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290116

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02272

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Loreley</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Loreley Grove</u>		STREET ADDRESS <u>Loreley Grove</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Charles</u> <u>Henry</u> <u>Brown</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>23</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 17, 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>? Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mrs Martha Brown- Loreley, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>May 1949 + March 21, 1951</u>		<u>Years</u>	
Antecedent cause(s) (b) <u>generalized arteriosclerosis</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>last</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>March 23</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>51</u> , and that death occurred at <u>10 P</u> m., from the causes and on the date stated above. SIGNATURE <u>Red O Hodous M.D</u> ADDRESS <u>Edgewood Md</u> DATE SIGNED <u>3-23-51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3-27-51</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Loreley, Balto., Md.</u>		DATE RECD BY LOCAL REG <u>3/26/51</u>		REGISTRAR'S SIGNATURE <u>R.D. Hedrick</u>	
FUNERAL DIRECTOR <u>Mr. Frances A. Hemley</u>		ADDRESS <u>522 W. Biddle St</u>		<u>290116</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02273
38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>318 Dixie Drive</u>		STREET ADDRESS (If rural, give location) <u>318 Dixie Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frances</u> (Middle) <u>Eudora</u> (Last) <u>Bunting</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>7</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 8, 1897</u>
9. AGE last birthday <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>
11. BIRTHPLACE (State or foreign country) <u>Charlotte, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jones</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Underwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS. <u>Alfred C. Bunting, (Husband) 318 Dixie Drive, Towson, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443x Immediate cause (a) <u>Heart disease, chronic myocarditis (with acute congestive failure)</u>		<u>3 yrs</u>	
93d Antecedent cause(s) (b) <u>Hypertension</u>		<u>20 yrs</u>	
(c) <u>Arteriosclerosis</u>		<u>Unknown</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>now</u> , 19 <u>51</u> , to <u>3/7</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/5</u> , 19 <u>51</u> , and that death occurred at <u>10 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Rollin C. Hudson M.D.</u>		DATE SIGNED <u>3/7/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3-9-1951</u>	NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>	LOCATION (City, town, or county) (State) <u>TOWSON MD.</u>
DATE REC'D BY LOCAL <u>3-8-51</u>	REGISTRAR'S SIGNATURE <u>Am Reduct</u>	24. FUNERAL DIRECTOR <u>H.W. JENKINS & SONS Co.</u> ADDRESS <u>4905 YORK RD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Timonium		CITY (If outside corporate limits, write RURAL and give nearest town) Timonium	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Oakway Road		STREET ADDRESS (If rural, give location) 2 Oakway Road	
3. NAME OF DECEASED (Type or Print) (First) Harry (Middle) Lee (Last) Burall		4. DATE OF DEATH (Month) March (Day) 5 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 30, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman Installer		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Burall		14. MOTHER'S MAIDEN NAME Emma Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give year or dates of service) WW #1		16. SOCIAL SECURITY No. 212-05-0736	
17. INFORMANT AND ADDRESS Mrs. Margaret Howard Burall Timonium, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Carcinoma of Lower Mandible				8 mos	
Antecedent cause(s) (b) Metastasis to Mediastinum				30 days	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (to the lungs)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **9/14**, 19**51**, to **3/5**, 19**51**, that I last saw the deceased alive on **3/5**, 19**51**, and that death occurred at **6:55 P.M.** from the causes and on the date stated above.

SIGNATURE **Bennett A. Stoen MD** ADDRESS **Lutherville, Md.** DATE SIGNED **3/6/51**

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE March 8, 1951		NAME OF CEMETERY OR CREMATORY Druid Ridge		LOCATION (City, town, or county) Pikesville, Maryland		(State)	
DATE REC'D BY LOCAL REG. 3/8/51		REGISTRAR'S SIGNATURE g w Hedman		24. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Road			

Horace F. Burgee 540578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

10-12
Today

Dr Platt
434 Eastern Ave
EUREK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02275

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Balto</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Elder Drive</u>		STREET ADDRESS <u>14 Elder Drive</u>	
3. NAME OF DECEASED (Type or Print) <u>Blanche</u> (First) <u>A.</u> (Middle) <u>Burton</u> (Last)		4. DATE OF DEATH <u>March 22, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>unmarried</u>	8. DATE OF BIRTH <u>June 29, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Dupua</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pettus</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret Madzarac</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260x Immediate cause (a)

Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

61

Acute Pulmonary Edema
Coronary Artery occlusion
Diabetes

INTERVAL BETWEEN ONSET AND DEATH

20 MINS.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Chronic myocarditis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work Not While At work	HOW DID INJURY OCCUR?		

22. I hereby certify that I, attended the deceased from 3/18, 1951, to 3/21, 1951, that I last saw the deceased

alive on 3/18, 1951, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE

D. Day Platt, M.D.

ADDRESS

434 Eastern Ave. Balto. 21

DATE SIGNED

3/21/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>3/22/51</u>	<u>Richmond</u>	<u>Richmond, Virginia</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>3/22/51</u>	<u>A.W. Hedden</u>	<u>Wm. E. Cook, Inc., 1212 E. Paul Street</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02276

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WATERS OF CHESAPEAKE		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN INVERNESS (BALTO. 22)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS BAY, OFF POOL'S ISLAND		STREET ADDRESS (If rural, give location) 1 SEABRIGHT AVE	
3. NAME OF DECEASED (Type or Print)	(First) HENRY (Middle) EDWARD (Last) BURTON	4. DATE OF DEATH (Month) 3 - (Day) 27 - (Year) 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 8/25/1897 53 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		9b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	9. AGE last birthday If under 1 year: Months 3 Days 27 Hours 19 Min. 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL	11. BIRTHPLACE (State or foreign country) KENTUCKY
13. FATHER'S NAME ROBERT BURTON		14. MOTHER'S MAIDEN NAME SUSAN RAE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service) ?		16. SOCIAL SECURITY No. 402-20-6962	
17. INFORMANT DELORAS MILLS BURTON - WIFE		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a)

850.8

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

1/2

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. ☒ PRIMARY ☐ CONTRIBUTING

PLACE (Home, farm, factory, street, office, etc.) OF INJURY **Pool's Bay**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **3-24-51 (7) m.**

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Caught in Bay's Stern in small boat

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED **3/28/51**

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 29-1951 William M. Kelly

WALTER BROOKS BRADLEY, DUNDALK, MD.

690336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

02277

Bc

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1209 Nolan Court</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ROBERT</u> (Middle) <u>P.</u> (Last) <u>BYAS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 29</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>3/14/88</u>
9. AGE last birthday <u>63</u> yrs.		10. If under 1 year: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Brick Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Major Byas</u>		14. MOTHER'S MAIDEN NAME <u>Addie Stephney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) CEREBRAL HEMORRHAGE

INTERVAL BETWEEN ONSET AND DEATH

Unknown

Antecedent cause(s)

(b) GENERALIZED ARTERIOSCLEROSISUnknown

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 29, 1951, to Mar. 29, 1951, and that death occurred at 6:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M.D., ACTING CHIEF MEDICAL SERV. VAH, FT. HOWARD, MD.3/30/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/3/51</u>	REGISTRAR'S SIGNATURE <u>a. J. [Signature]</u>	24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave. Balto. Md.</u>		ADDRESS

970318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02278

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>none</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Towson Convalescent Home</u> <u>301 W. Chesapeake Avenue</u>		STREET ADDRESS (If rural give location) <u>100 W. University Parkway</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Edith Frost Campbell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 2 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 10, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Albany, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John R. Frost</u>		14. MOTHER'S MAIDEN NAME <u>Frances Steuf</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Francis Campbell - 4307 Wendover Rd., Balto.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Convalescence from pneumonia

(c) Cerebral hemorrhage, Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

30 min.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 21, 1951, to March 2, 1951, that I last saw the deceased

alive on March 1, 1951, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John H. Truesher, M.D.

1035 N. Calvert St.

March 3, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>3 - 5 - 51</u>	<u>Albany Rural</u>	<u>Albany, New York</u>	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/3/51</u>	<u>A. W. H. H. H.</u>	<u>John O. Mitchell & Sons, Inc.</u>	<u>1900 Eutaw Place</u>

M. B. Mitchell Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *me* *45*

02279

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>3450 Roland Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES</u> <u>(NMI)</u> <u>CAMPTON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 10</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-26-94</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> <u>C. M. Kest</u>	
11. BIRTHPLACE (State or foreign country) <u>Los Angeles Co. California</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Campton</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Heller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No. <u>188-03-9436</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>Unknown</u>	
Immediate cause (a) <u>Carcinoma of Lung</u>			
Antecedent cause(s) (b) <u>163x</u> <u>47d</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that <u>X</u> attended the deceased from <u>Mar. 6</u> , 19 <u>51</u> , to <u>Mar. 10</u> , 19 <u>51</u> , <u>that I have seen the deceased</u> <u>and that death occurred at 6:50 P.m., from the causes and on the date stated above.</u> SIGNATURE <u>Lawrence J. Knox, M.D.</u> (Degree or title) ADDRESS <u>VETERANS ADMINISTRATION FORT HOWARD, MD.</u> DATE SIGNED <u>3-10-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/13/51</u>	<u>Baltimore National</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-12-51</u>	<u>L</u>	<u>William Cook, Inc.</u>	<u>Preston & St. Paul St. Balto., Md.</u>

554459

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02280

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2708 Arbutus Avenue</u>		STREET ADDRESS (If rural, give location) <u>2708 Arbutus Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GUSTIF</u> (Middle) <u>GAETANO</u> (Last) <u>CAPELOTTI</u>	4. DATE OF DEATH <u>March 23, 1951</u> 19 <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1911</u> 40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sew</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>40</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Boston Mass</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>sew</u>		14. MOTHER'S MAIDEN NAME <u>sew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

981x Immediate cause (a) Multiple gunshot wounds of chest
 166 Antecedent cause(s) (b) Gunshot wound of head
 Diseases not conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>home</u>	(CITY OR TOWN) <u>2708 Arbutus Avenue, Baltimore, Md.</u>	(COUNTY) <u>Baltimore</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 23, 1951</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Firearms</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, (Specify) <u>March 30, 1951</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>South Boston Mass</u>	LOCATION (City, town, or county) (State) <u>Mass</u>
DATE REC'D BY LOCAL REG. <u>3/26/51</u>	REGISTRAR'S SIGNATURE <u>W. W. Redman</u>	24. FUNERAL DIRECTOR <u>Charles W. Rachowski</u>	ADDRESS <u>703 McHenry St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for additions of 7 shown on: MARYLAND STATE DEPARTMENT OF HEALTH

02281

FILM No. G. 131 APR 2 1951

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2708 Arbutus Avenue</u>		STREET ADDRESS (If rural, give location) <u>2708 Arbutus Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u> (Middle) <u>LAVONIS</u> (Last) <u>CAPELOTTI</u>	4. DATE OF DEATH <u>March 23, 1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	9. AGE last birthday <u>40</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Chas. Burn</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>North Ph RL Ind.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Multiple gunshot wounds of chest

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Gunshot wound of neck(c) Intra thoracic hemorrhage

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, office, bldg., etc.) INJURY <u>home</u>	(CITY OR TOWN) <u>2708 Arbutus Ave., Arbutus, Baltimore, Md.</u>	(COUNTY) <u>Baltimore</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 23, 1951</u> p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Firearms</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>3/28/51</u>	<u>London Park</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
<u>3/27/51</u>	<u>Rev. J. J. J. J. J.</u>	<u>Rev. J. J. J. J. J.</u>	

Dm

Kucharskoe 390418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02282

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.City or town Towson, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

429 E. Penna. ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Towson
(If outside city or town limits, write RURAL and give nearest town)Street No. 429 E. Penna. ave.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Thomas E. Chaney

3. (b) Social Security Number

none

4. Sex

m

5. Color or race

c

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mabel Chaney

7. Birth date of

deceased (mo., day, yr.)

Dec. 3, 18756.(c) If alive, give age deceased years

8. AGE:

Years

Months

Days

If less than one day

7535

hrs.

min.

9. Birthplace

Towson, Md.
(Town, county, and state)

10. Usual occupation

Business

11. Industry or business

Store

FATHER

12. Name

Lewis Chaney

13. Birthplace

unknown

MOTHER

14. Maiden name

Mary Scott

15. Birthplace

Balto. Co. Md.

18. Informant

Robert Chaney

Address

429 E. Penna. ave. Towson, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

3/11/51
(month) (day) (year)

Cemetery or crematory

Pleasant Rest

Location

Towson, Md.

18. Funeral director

Wm. J. Chatman Jr.

Address

1701 M. E. Culler St. Balto. Md.

19.

(Date rec'd by registrar)

3/9/57G. W. [unclear]
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 819571300

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 11950

to

Mar 81957

and that I last saw him alive on

Mar 81957

Immediate cause of death

Chronic Myocarditis

DURATION

1 yr. 3 mo

Due to

Due to

Other conditions

422.2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. J. Chatman Jr.

M. D. or other

Address

2329 Queen St.Date signed Mar 8 57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1122843

1. PLACE OF DEATH- COUNTY <u>Balto Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7842 Belair Rd</u>		STREET ADDRESS (If rural, give location) <u>7842 Belair Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Asbury</u> (Middle) <u>G</u> (Last) <u>Chenoweth</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>27</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 8 1865</u>
9. AGE last birthday <u>85</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore Co</u>
13. FATHER'S NAME <u>Asbury G. Chenoweth</u>	14. MOTHER'S MAIDEN NAME <u>Anna J. Sanders</u>	17. INFORMANT AND ADDRESS <u>Mrs. Clifton Kidd 7842 Belair Rd</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>None</u>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Myocardial infarction</u>	
Antecedent cause(s) <u>422.1</u>		(b) <u>chronic myocarditis</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>93d</u>		(c) <u>arterio-sclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at <input type="checkbox"/> Not While at <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 15</u> , 19 <u>51</u> , to <u>March 27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>51</u> , and that death occurred at <u>6 p.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>S. E. Gerson</u>		DATE SIGNED <u>March 27 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-30-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Hiss Meth Cem</u>	LOCATION (City, town, or county) <u>Balto, Co - Md</u>
DATE REC'D BY LOCAL REG. <u>Mar. 30-1951</u>	REGISTRAR'S SIGNATURE <u>Ms. G. L. Reifner</u>	24. FUNERAL DIRECTOR <u>Leascher Funeral Home 7401 Belair Rd</u>	

400806

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 2 1951
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

02284

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 Allegheny Avenue</u>		STREET ADDRESS (If rural give location) <u>29 Allegheny Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u>	(Middle) <u>HENRY</u>	(Last) <u>CHESTER</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 19, 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Fire Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Co.</u>	9. AGE last birthday <u>87</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Ethel S. Chester -</u>		<u>29 Allegheny Ave. Towson, Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>			<u>?</u>
420.0 Antecedent cause(s) (b) <u>Hypertrophied Heart</u>			<u>5 days</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Auricular Fibrillation</u>			<u>5 days</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis</u>			<u>?</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Terminal Bronchopneumonia</u>	20. AUTOPSY? <u>5 days</u>
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE) <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1940, to 3-30, 1951, that I last saw the deceased alive on 3-30, 1951, and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE [Signature] M.D. 3105 N. Charles St. DATE SIGNED 3-30-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE April 2, 1951 NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.

DATE REC'D BY LOCAL REG. 4/2/51 REGISTRAR'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR JOHN BURNS' SONS, TOWSON, MD. ADDRESS

762 916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02285

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>English Consul</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>English Consul</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4435 Palmer Rd</u>		STREET ADDRESS (If rural, give location) <u>4435 Palmer Rd</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Foster</u> (Middle) <u>H</u> (Last) <u>Clark</u>		(Month) <u>Mar</u> (Day) <u>20</u> (Year) <u>57</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 16, 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>usa</u>	9. AGE last birthday <u>33</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Madison Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Alex J Clark</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Drason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes 1950</u>		16. SOCIAL SECURITY No. <u>7750</u>	
17. INFORMANT AND ADDRESS <u>Grace Clark wife</u>			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>acute cardiac failure</u>			?
Antecedent cause(s) (b) <u>Pulmonary tuberculosis</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. [Signature]</u>		DATE SIGNED <u>Mar 20 57</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>30-33-51</u>	NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL CEM</u>
LOCATION (City, town, or county) <u>BALTO</u>		(State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>3/24/57</u>		24. FUNERAL DIRECTOR <u>Bernard E Harbo</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>131 E West St</u>	

595916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

C-15302186

02286

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Port Howard, Md.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ft. Howard U.S. Hosp.</u>				STREET ADDRESS (If rural, give location) <u>37 E. Randall St.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Howard</u> (Middle) <u>J.</u> (Last) <u>Clem</u>		4. DATE OF DEATH		(Month) <u>Mar</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>2/4/94</u>	9. AGE last birthday <u>57</u> yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shop operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Barrell Making</u>		11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>	
13. FATHER'S NAME <u>Charles Clem</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes - WW-1</u>				16. SOCIAL SECURITY No. <u>215-07-0219</u>		17. INFORMANT AND ADDRESS <u>Clinical Record Vets Adm. Hosp. Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Generalized carcinomatosis</u>						7 months	
Antecedent cause(s) (b) <u>Carcinoma of the urinary bladder</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						3 yr.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>5/25/50</u>				19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of urinary bladder</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 8, 1951</u> , to <u>March 10, 1951</u> , that I last saw the deceased <u>alive on March 10, 1951</u> and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Ft. Howard U.S. Hosp.</u>		DATE SIGNED <u>3/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>March 14, 1951</u>		<u>Balt. U.S. Nat'l C. Cem.</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-12-51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Howard Evans</u>		ADDRESS <u>Balt. 30, Md. 1400 S. Chas. St.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02287

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>	
TOWN <u>1525 Rolling Rd</u>		TOWN <u>1525 Rolling Rd</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Carrie</u> (Middle) <u>S.</u> (Last) <u>Coard</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>3</u> (Year) <u>1947</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 24-1864</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>house</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Sumner</u>		14. MOTHER'S MAIDEN NAME <u>Melissa Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs Margaret Rother 1525 Rolling Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial insufficiency

Antecedent cause(s)

(b) Due to infirmities of age

(c) general arteriosclerosis

(d) senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from Sept 10, 1940, to Feb 3, 1947, that I last saw the deceased

alive on Feb 2, 1947, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION RE-INTERMENT (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/5/57

A W [Signature]

4th Co. Inc. 1217 St. Paul St

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02288

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Harrison</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Princeton Town</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salem</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Lewis</u>	(Last) <u>Collins</u>
4. DATE OF DEATH	(Month) <u>Mar</u>	(Day) <u>7th</u>	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>Jan 31-1880</u>
9. AGE last birthday <u>71</u> yrs.		If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>General Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Salem W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard Collins</u>		14. MOTHER'S MAIDEN NAME <u>Julia Haymond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. <u>48-111-1000</u>	
17. INFORMANT <u>Mrs Mary Collins</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
410 x Immediate cause (a) <u>Heart disease, valvular, initial, with decompensation</u>				2 1/2 yrs	
92 b Antecedent cause(s) (b) <u>Arthritis, extremities (type undetermined)</u>				Unknown	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 23</u> ..., 1950..., to <u>March 7</u> ..., 1951..., that I last saw the deceased alive on <u>March 7</u> ..., 1951..., and that death occurred at <u>1:30 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Rollins B. Hudson MD.</u>		ADDRESS <u>Townson Md</u>		DATE SIGNED <u>3/7/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <u>Mar 10-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Princeton Methodist</u>	
LOCATION (City, town, or county) <u>Harrison Md</u>		24. FUNERAL DIRECTOR <u>John Buono</u>		ADDRESS <u>610 York Rd Towson, Md</u>	
DATE REC'D BY LOCAL REG. <u>3-8-51</u>		REGISTRAR'S SIGNATURE <u>L</u>		564246	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

02289

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>230 Oakwood Rd</u>		STREET ADDRESS (If rural, give location) <u>230 Oakwood Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JENNIE</u>	(Middle)	(Last) <u>COMITALE</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-12-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday <u>70</u> yrs.	4. DATE OF DEATH (Month) <u>MAR.</u> (Day) <u>15</u> (Year) <u>1951</u>
13. FATHER'S NAME <u>Joe Bruno</u>	12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT <u>John Comitale</u>		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Virus</u>	<u>Pneumonia</u>	<u>3 days</u>
492K Antecedent cause(s)	(b) <u>Myocardial disease</u>		<u>10 years</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Hypertension</u>		<u>2</u>
II. OTHER SIGNIFICANT CONDITIONS		<u>Obesity</u>	<u>2</u>
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1950, to March 15, 1951, that I last saw the deceased alive on March 15, 1951, and that death occurred at 2 a m., from the causes and on the date stated above.

SIGNATURE Morris A. Jacob (Degree or title) MD ADDRESS 1010 North Point Rd DATE SIGNED 3/15/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>3-15-51</u>	<u>St Dominicks Cem.</u>	<u>Phila., Penna.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-15-51</u>	<u>aw Henrich</u>	<u>John S. Connolly</u>	<u>-418 Eastern Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02290

Reg. Dist. No. 35

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Pennsylvania</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Freedom</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stockton Road</u>				STREET ADDRESS (If rural give location) <u>R.D.</u>			
3. NAME OF DECEASED (Type or Print) <u>Iven G. Cooke</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 19 1951</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 6, 1894</u>		9. AGE last birthday <u>57</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>			
11. BIRTHPLACE (State or foreign country) <u>Vilas, N. C. (Blue Ridge)</u>				12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>			
13. FATHER'S NAME <u>Adam Cooke</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cable</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or service) <u>World War I</u>				16. SOCIAL SECURITY No. <u>246-05-9814</u>			
17. INFORMANT <u>Olen Cooke, Stewartstown Pa.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Heart disease, vascular, coronary occlusion</u>						<u>Sudden</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Rollin C. Hudson M.D., D.M.E.</u>				DATE SIGNED <u>3/19/51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				DATE THEREOF <u>March 20, 1951</u>			
NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>				LOCATION (City, town, or county) (State) <u>Vilas, Watauga Co. N. C.</u>			
DATE REC'D BY LOCAL REG. <u>3/20/51</u>				REGISTRAR'S SIGNATURE <u>Charles E. Fulton</u>			
				24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom, Pa.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02291

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodlawn		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Woodlawn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6429 Windsor Mill Rd.				STREET ADDRESS (If rural, give location) 6429 Windsor Mill Rd.	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
JOSEPHINE		JOHNSTON		COOMES	March 31 1951
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH June 21, 1864	9. AGE last birthday 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME McKendree Peddicord		14. MOTHER'S MAIDEN NAME Mary Micholson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Mrs. W. E. Stewart - 6429 Windsor Mill Rd	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
422.1 Immediate cause		(a) Chronic Myocardial Degeneration		six years	
93d Antecedent cause(s)		(b) Arterio sclerosis		ten years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) Saunility			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION No operation		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 20, 1951**, to **March 31, 1951**, that I last saw the deceased alive on **March 30, 1951**, and that death occurred at **10:20 A.M.**, from the causes and on the date stated above.

SIGNATURE **Joshua H. Armacost M.D.** ADDRESS **6419 Windon Hill Rd** DATE SIGNED **March 31 1951**

23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE 4/3/51	NAME OF CEMETERY OR CREMATORY Linthicum Chapel	LOCATION (City, town, or county) Clarksville, Md.	(State)
DATE REC'D BY LOCAL REG. 4/2/51		REGISTRAR'S SIGNATURE A W Hedrick		24. FUNERAL DIRECTOR Wm. J. Linkner & Sons - Balt	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02292

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wanam Road</u>		STREET ADDRESS <u>Wanam Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Amelia</u> (First) <u>—</u> (Middle) <u>Corbin</u> (Last)		4. DATE OF DEATH <u>March 1</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-3-1852</u> 98 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>98</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Ed. Corbin, Cockeysville, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Arteriosclerotic heart disease</u>		<u>years</u>
Antecedent cause(s) (b) <u>4200</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>B1 ind - bilateral catenars</u>		<u>years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec 28, 1950, to Feb 28, 1951, that I last saw the deceased alive on Feb 28, 1951, and that death occurred at 12:10 P.M., from the causes and on the date stated above.

SIGNATURE Elizabeth B. Sherrill M.D. ADDRESS Cockeysville, Md. DATE SIGNED 3/1/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar. 4, 1951</u>	<u>Poplar Grove</u>	<u>Cockeysville, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/1/51</u>	<u>W. J. Whitcomb</u>	<u>James M. Brooks, Sparks, Md</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02293

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore,</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Presbyterian Home</u>		STREET ADDRESS (If rural give location) <u>Presbyterian Home 2215 Rodin Rd</u>	
3. NAME OF DECEASED (First) <u>Edith</u> (Middle) <u>R.</u> (Last) <u>Cornelius</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>April 28, 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lewisberg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John R. Cornelius</u>		14. MOTHER'S MAIDEN NAME <u>Hannah M. Kieffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		17. INFORMANT <u>Mrs. T. E. Elliott Presbyterian Home Towson Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

2 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-sclerosis & Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar 15, 1951, to Mar 28, 1951, that I last saw the deceasedalive on Mar 28, 1951, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/2/51</u>	<u>Lewisberg</u>	<u>Lewisberg, Pa.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/2/51</u>	<u>A. W. Hedrick</u>	<u>John O. Mitchell Sons</u>	<u>1900 Eutaw Place</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ~~XX~~

bc 02294

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fort Howard</u>	LENGTH OF STAY (In this place) <u>378 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>546 St. Mary Street</u>	
3. NAME OF DECEASED (First) <u>ARTHUR</u> (Middle) <u>(NMI)</u> (Last) <u>CORNISH</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>29</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-29-86</u>
		9. AGE last birthday <u>65</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cafeteria</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Solomon Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>212-07-1394</u>	
		17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) Diabetes Mellitus, mild

unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

Osteomyelitis, chronic, right tibia
Neuropathy, secondary to #1

unknown

unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 16, 1950, to March 29, 1951, that I last saw the deceased

live on March 29, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. C. MANAUGH, M.D., CHIEF, PROFESSIONAL SERV., VET. ADM. HOSP. FT. HOWARD, MD.

3/30/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

4-2-1951

Baltimore National

Baltimore, Maryland

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/30/51

A.W. Hedrick

Katie Williams

322 N. Schroeder St., Balto. Md

754679

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BIRTH NO.				CERTIFICATE OF DEATH				Registered No.			
1. NAME OF DECEASED (Type or Print)				MARTHA A. COTTRELL				2. DATE OF DEATH Mar. 8, 1951			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				B. COUNTY Baltimore			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
6500 Crestwood Rd.				Baltimore Co.				6500 Crestwood Rd.			
c. Length of stay in Baltimore				Yrs. Mos. Days							
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years, last birthday)		If Under 1 Year Months: Days	
female		white		widowed		Jan. 29, 1874		77			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
housewife				at home				Virginia			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
James Alley				Emma Smoot							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
								Mrs. J. C. Rigger - 6500 Crestwood Rd.			
18. CAUSE OF DEATH								INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)								Many Yrs.			
416x ANTECEDENT CAUSES								Unknown			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.								6 Yrs +			
95b											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug, 1950, to Feb 8, 1951, that I last saw the deceased alive on 3-3, 1951, and that death occurred at 9 A. m., from the causes and on the date stated above.											
23A. SIGNATURE				23B. ADDRESS				23C. DATE SIGNED			
B. B. Euser				7201 York Rd.				3-8-51			
24A. BURIAL, CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
Removal				3/9/51				Riverview Cem.			
24D. LOCATION (City, town, or county) (State)				25. FUNERAL DIRECTOR ADDRESS							
Richmond, Va.				Wm. J. Tiekner & Sons - Balt				Md			
DATE RECEIVED BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE							
MAR 9 - 1951				A. H. Hedrick							
VS 150											

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02296

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Sta Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL Baltimore</u> LENGTH OF STAY <u>Whole life</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL Bellona Ave + Brightside Rd.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bellona Ave + Brightside Rd</u>				STREET ADDRESS <u>Bellona Ave + Brightside Rd</u>			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
<u>Sally</u>		<u>Franklin</u>		<u>Cromwell</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	4. DATE OF DEATH		
<u>Female</u>	<u>White</u>	<u>WIDOWED</u>	<u>Nov 4-1872</u>	<u>78</u> yrs.	<u>March 12</u>		<u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>OWN home</u>		<u>Balto County Md</u>	
12. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Col. Walter S. Franklin</u>				<u>Mary C. Small</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
<u>No</u>				<u>—</u>		<u>W.R. Cromwell Jr</u> <u>Brightside Rd</u> <u>Balto 12 Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170x Immediate cause (a) <u>Carcinoma of Breast</u>							
50 Antecedent cause(s) (b) <u>—</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>July 1950</u>				<u>adenocarcinoma</u>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
				INJURY			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF		While at Not While					
INJURY		m. Work <input type="checkbox"/> At work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>50</u> , to <u>March 12</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>51</u> , and that death occurred at <u>11:30 A</u> m., from the causes and on the date stated above.							
SIGNATURE				(Degree or title)		DATE SIGNED	
<u>Francis M. Gluck</u>				<u>M.D.</u>		<u>3/13/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar 14 1951</u>		<u>Green Mount</u>		<u>Balto. Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/13/51</u>		<u>C.W. Hedrick</u>		<u>Henry J. Jenkins & Son Co</u>		<u>4905 York Rd.</u>	

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

02297

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETS..ADM..HOSP. FT.Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1416 McCulloh St.</u>	
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>M.</u> (Last) <u>DAY</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>25</u> (Year) <u>19 51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>2-5-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>utility man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Fredericksburg, Va.</u>		12. CITIZEN OF WHAT Country? <u>USA</u>	
13. FATHER'S NAME <u>George J Day</u>		14. MOTHER'S MAIDEN NAME <u>Emma Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets..A..m..Hosp..Ft..Howard, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause	(a) <u>Cerebrovascular accident probably thrombotic</u>	unknown
98d Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertensive Cardiovascular Disease</u>	10 yrs.
(c)		

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 15, 1951, to Mar. 25, 1951, that I last saw the deceasedon Mar. 25, 1951, and that death occurred at 12:15 P.m., from the causes and on the date stated above.SIGNATURE Harold Gabel (Degree or title) ADDRESS DATE SIGNED

HAROLD GABEL, M.D. VETERANS ADMINISTRATION FORT HOWARD, MARYLAND 3-25-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-29-51</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) (State) <u>5501 Frederick Ave. Balto. Md.</u>
DATE REC'D BY LOCAL REG <u>3/27/51</u>	REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Geo. Gibson</u>	ADDRESS <u>1735 Druid Hill Ave. Balto. Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690426

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

02298

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
TOWN <u>OPITZ NURSING HOME</u>		TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>OPITZ NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>2217 W. BALTIMORE ST.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>MARY</u> (Middle) <u>CATHERINE</u> (Last) <u>DECKER</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>DEC. 29, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>86</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AUGUST DEGENHARDT</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE GREENAWALT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>MRS. ESTELLA WATKINS - 2217 BALTO. ST.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Anterior electric C. V. disease</u>			<u>5 yrs</u>
Antecedent cause(s) (b) <u>422.1</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) <u>OF INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jun, 1946, to March, 1951, that I last saw the deceased alive on 3/14, 1951, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	(Degree or title)	ADDRESS <u>1945 W. Balto St</u>	DATE SIGNED <u>3/17/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>3-19-51</u>	NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD.</u>
DATE REC'D BY LOCAL REG. <u>3/19/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>George A. Farley</u>	ADDRESS <u>1000 Fayette St.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 22 1951
U.S. DEPT. OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02299

Reg. Dist. No. 35

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>12</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTO. CITY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7908 OLD HARFORD RD.</u>		STREET ADDRESS (If rural, give location) <u>1228 AUGUSTA AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>ANNIE</u>	(Middle) <u>E.</u>	(Last) <u>DEMINNIS</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>23</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	8. DATE OF BIRTH <u>FEB. 17, 1885</u>
13. FATHER'S NAME <u>PINZER</u>		9. AGE last birthday <u>66</u> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
16. SOCIAL SECURITY No. <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. R. Coback 1228 Augusta Ave.</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Heart failure.

Antecedent cause(s)

61

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive O.V.D. with generalized arteriosclerosis many years(c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

stat.several years

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on March 23, 1951, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 26, 1951Dr. A. M. BaconJames L. McElroy 130 E. FORT. AVE.

8300 Harvard Rd



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02300

CERTIFICATE OF DEATH

Reg. Dist. No. 40

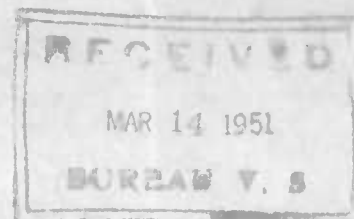
1. PLACE OF DEATH- COUNTY <i>Balt. Co.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>md.</i> COUNTY <i>Balt.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Joseph</i>	(Middle) <i>Dilworth</i>	(Last) <i>Dilworth</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 16-1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Robert Dilworth</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Ramsey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <i>Mrs Anne E. Dilworth</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause (a) <i>Cerebral Hemorrhage</i>			<i>8 days</i>
83a Antecedent cause(s) (b) <i>Chronic Arthritis</i>			<i>2 yrs</i>
(c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <i>Arteriosclerosis</i>			<i>2 yrs</i>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>March</i> , 19 <i>49</i> , to <i>Mar 17</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>Mar 17</i> , 19 <i>51</i> , and that death occurred at <i>March</i> , 19 <i>51</i> , from the causes and on the date stated above.			
SIGNATURE <i>Arthur M. Hammett</i>		ADDRESS <i>Baldwin</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Mar 9-51</i>	NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove</i>
DATE REC'D BY LOCAL REG. <i>3/14/50</i>		REGISTRAR'S SIGNATURE <i>Arthur M. Hammett - wa.</i>	24. FUNERAL DIRECTOR <i>C. E. Arthur</i>
		ADDRESS <i>Fork md.</i>	

290/16

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Co
COPY SENT TO LOCAL REGISTRAR No. _____ DATE 2/14/50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 35

02301

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>	
TOWN <u>Bernoudy Rd.</u>		TOWN <u>Bernoudy Rd.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bernoudy Rd.</u>		STREET ADDRESS (If rural, give location) <u>Bernoudy Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Albert</u> (Middle) <u>Bernard</u> (Last) <u>Doll</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1951</u>	
6. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 28, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>0</u> yrs. If under 1 year Months <u>13</u> Days <u>13</u> Min.
11. BIRTHPLACE (State or foreign country) <u>White Hall Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert B. Doll</u>		14. MOTHER'S MAIDEN NAME <u>Nanalee Hamm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Albert B. Doll - White Hall, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia BIRTHAntecedent cause(s) (b) (7 month Congestion)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/28, 1951, to 3/28, 1951, that I last saw the deceased alive on 3/28, 1951, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/29/51</u>	<u>Stablersville Cem.</u>	<u>Parkton, Balto. Co., Md.</u>	<u>Pa.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FURNERAL DIRECTOR		ADDRESS
<u>3/29/51</u>	<u>Chester L. Frazier</u>	<u>Jacob Hartenstein</u>		<u>New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH *PC*
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02302

Reg. Dist. No. *42*

1. PLACE OF DEATH- COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>md</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Catonsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Balto</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>98 Smithwood and Wayne Nursing Home</i>		STREET ADDRESS (If rural, give location) <i>614 Lakewood Ave</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>George</i>	(Middle) <i>Howard</i>	(Last) <i>Kressel</i>
4. DATE OF DEATH	(Month) <i>Mar</i>	(Day) <i>20</i>	(Year) <i>57</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>July 11 1885</i>
9. AGE last birthday <i>65</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>never employed</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>George Kressel</i>		14. MOTHER'S MAIDEN NAME <i>Fredenka ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) <i>Acute Cardiac failure</i>			
Antecedent cause(s) (b) <i>Cardiovascular disease</i>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <i>Dr. J. H. Kieffer M.D. Cap. Med.</i>		DATE SIGNED <i>Mar 20 57</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>3-22-57</i>	NAME OF CEMETERY OR CREMATORY <i>Our Carmel Cem</i>	LOCATION (City, town, or county) <i>Balto</i> (State) <i>md</i>
DATE REC'D BY LOCAL REG. <i>Mar 20 57</i>	REGISTRAR'S SIGNATURE <i>J. H. Kieffer</i>	24. FUNERAL DIRECTOR ADDRESS <i>Jim Cook Inc 1217 St Paul St</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30690



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Arbutus Road,</u>		STREET ADDRESS (If rural, give location) <u>243 S. Chester St.,</u> ✓	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Clarence</u> <u>Eaton</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 7, 1951</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 13, 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Lieutenant retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas J. Eaton</u>		14. MOTHER'S MAIDEN NAME <u>Ernestine F. May</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Clarence L. Eaton 925 Chestnut Hill Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cirrhosis of liver</u>		<u>Dec 16/50</u>
Antecedent cause(s) (b) <u>581.0</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>124.6</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>none</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>none</u>

22. I hereby certify that I attended the deceased from Dec 15, 1950, to Mar 7, 1951, that I last saw the deceased alive on Jan 6, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

March 10, 1951 R.W. Ullrich Funeral Home 2008 Orleans St.,

(Office) 290936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
BALTIMORE MARYLAND		BALTIMORE MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	
BALTIMORE MARYLAND		BALTIMORE MARYLAND	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
JAMES (First) (Middle) (Last)		MARCH 21 1957	
SEX		AGE last birthday	
Male		74 yrs.	
5. COLOR OR RACE		6. DATE OF BIRTH	
White		MAY 25 1876	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. BIRTHPLACE (State or foreign country)	
Married		England	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. KIND OF BUSINESS OR INDUSTRY	
Old Man's Head		Unknown	
11. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		American	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME	
No		SARAH (Unknown)	
15. SOCIAL SECURITY No.		16. INFORMANT AND ADDRESS	
Unknown		J. J. Schell 6013 Gwynn Park Ave	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		3 yrs	
442x Immediate cause (a) Chronic Myocardial Degeneration		2 yrs -	
131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		Maintain	
(b) Chronic Nephritis			
(c) Arteriosclerosis			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		20. AUTOPSY?	
19b. MAJOR FINDINGS OF OPERATION		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from....., 19....., to Mar 21, 1957, that I last saw the deceased alive on Mar 21, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 24 1957

R.W.

1217 St Paul St

050216

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BIRTH NO.				CERTIFICATE OF DEATH		Registered No. <u>0230538</u>	
1. NAME OF DECEASED (Type or Print) <u>Katherine J. Eichler</u>				2. DATE OF DEATH <u>Mar 21, 1951</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Towson</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Towson</u>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>E. Joppa Road</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Towson</u>			
c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>				D. STREET ADDRESS (If rural, give location) <u>E. Joppa Road</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar 6, 1866</u>		9. AGE (In years last birthday) <u>85</u>	10. Under 1 Year Months: <u>0</u> Days: <u>0</u> Hours: <u>0</u> Min. <u>0</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Frederick Guttensohn</u>				12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Louise Eichler</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>440X ANTECEDENT CAUSES</u> <u>131a</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Acute Pulmonary congestion</u> DUE TO (B) <u>Arteriosclerotic Cardiovascular System</u> DUE TO (C) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 yrs?</u>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 15, 1950</u> , to <u>March 21, 1951</u> , that I last saw the deceased alive on <u>March 21, 1951</u> , and that death occurred at <u>11:50 a.m.</u> , from the causes and on the date stated above.							
23A. SIGNATURE <u>E. J. Blight</u>				23B. ADDRESS <u>6217 Hayford Rd</u>		23C. DATE SIGNED <u>3/22/51</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/24/51</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		24D. LOCATION (City, town, or county) (State) <u>Taylor Ave Md</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>3-22-51</u>		REGISTRAR'S SIGNATURE <u>L</u>		25. FUNERAL DIRECTOR <u>Mildred J. Blight, 6009 Hayford Rd</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02306

FILM No. G 151 MAR 28 1951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Anne Ar.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gowans</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gowans</u>	
TOWN <u>Gowans</u>		TOWN <u>Gowans</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Meadow Rd. Homing Dr. B.M. Baker -</u>		STREET ADDRESS (If rural, give location) <u>Balt Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mary</u>	(Middle) <u>Hawkins</u>	(Last) <u>Ellis</u>
5. SEX <u>7</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MD</u>	8. DATE OF BIRTH <u>29 July 1888</u>
			9. AGE last birthday <u>61</u> yrs. If under 1 year: Months <u>13</u> Days <u>13</u> Hours <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Charles Hawkins</u>		1613 Lathrop St.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension

(c) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

? 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1946, to md, 1951, that I last saw the deceased alive on md 13, 1951, and that death occurred at 8 A.m., from the causes and on the date stated above.

SIGNATURE Benj. M. Baker Jr. (Degree or title) ADDRESS 9 E. Char St. Balt. Md. 13 md 51 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-17-51</u>	<u>mt Calvary Cmn</u>	<u>A. A. Co md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-15-51</u>	<u>R W Hechrich</u>	<u>Rayner Sanders</u>	<u>1412 E. Preston St</u>

720826

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02307

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Salto Md</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pa</u> COUNTY <u>Berks Co</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chambersville Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Boyerstown Pa</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8. S. Beechwood</u>		STREET ADDRESS (If rural, give location) <u>319 E. 8th Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>IRVIN</u> (First) <u>N.</u> (Middle) <u>ERB</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 23, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photography</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Erb</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs V. F. J. Spierdiedt Catonsville</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Thrombosis abdominal Aorta</u>				<u>1 hr</u>	
422.1 Antecedent cause(s) (b) <u>Myocarditis</u>				<u>2 wks</u>	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arterio sclerosis</u>				<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>45</u> , to <u>March 24</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>51</u> , and that death occurred at <u>4:15 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>W. S. S. Foster</u>		(Degree or title) <u>20 E. Preston St. Baltimore, Md</u>		DATE SIGNED <u>March 24, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>—</u>		DATE <u>3/27/51</u>		NAME OF CEMETERY OR CREMATORY <u>Barview Cemetery Boyertown Pa</u>	
LOCATION (City, town, or county) (State) <u>Boyerstown Pa</u>		24. FUNERAL DIRECTOR <u>—</u>		ADDRESS <u>—</u>	
DATE REC'D BY LOCAL REG. <u>3/25/51</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		24. FUNERAL DIRECTOR <u>—</u>	

074849

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 26 1951
LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH

02308

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1641 N. Caroline Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>H.</u> (Last) <u>EVANS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 17</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-25-90</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor (Unemployed)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) CARCINOMA OF RIGHT LUNGUNKNOWN

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that VA attended the deceased from Feb. 16, 1951, to March 17, 1951.XXXXXX and that death occurred at 6:25 A.M., from the causes and on the date stated above.SIGNATURE Eugene R. Kutz, M.D. (Degree or title)

ADDRESS

DATE SIGNED

EUGENE R. KUTZ, M.D.VAH, FORT HOWARD, MARYLAND3/18/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>3/17/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Avenue</u> <u>Baltimore 1, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

2706/VV

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

02309

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in the Pines 16 Rusting Ave.		STREET ADDRESS (If rural, give location) 1101 Woodington Rd.	
3. NAME OF DECEASED (First) Irvin S. (Middle) Fechtig (Last)		4. DATE OF DEATH (Month) March (Day) 1 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 10, 1881
9. AGE last birthday 70 yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY O'Sullivan Bldg.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Bumert Fechtig		14. MOTHER'S MAIDEN NAME Mary-----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 416 12 7566	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Mrs. Daniel Dennis, 1101 Woodington RD	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-31, 1951, to 3-1, 1951, that I last saw the deceasedalive on 3/1, 1951, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Burial

3/3/51

Holy Cross

A.A.Co., Md.

3/3/51

A W [Signature]

Harry H. [Signature]

1201 Edmondson Ave

583 VVV

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02310

Reg. Dist. No. Y3

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> LENGTH OF STAY (In this place) <u>25 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5809 Hornview ave</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Edward</u> (First) <u>F.</u> (Middle) <u>Foreman</u> (Last)		4. DATE OF DEATH <u>Mar 16</u> (Month) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 28 1906</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baltimore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>car operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Lida Macabee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-09-3835</u>	
17. INFORMANT <u>Edward A Foreman</u>		<u>5825 Westwood Ave</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary occlusion

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

Dr. McQuinn M.D.

(Degree or title)

ADDRESS

Baltimore Co. Dundalk 22 Md

DATE SIGNED

3/16/51

23. BURIAL, CREMATION REMOVAL (Specify)

Burial

DATE THEREOF

3/19/51

NAME OF CEMETERY OR CREMATORY

Baltimore, Cen

LOCATION (City, town, or county)

Balta.

(State)

MD

DATE REC'D BY LOCAL REG.

3/19/51

REGISTRAR'S SIGNATURE

R W Hedrick

24. FUNERAL DIRECTOR

Luzanne Funeral Home 401 Belair Rd. Balt Co

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

635516

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto. City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Reisterstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore-30</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Silver Cross Home</u>		STREET ADDRESS (If rural give location) <u>1266 Washington Blvd.</u>	
3. NAME OF DECEASED (First) <u>Doris</u>	(Middle) <u>Florence</u>	(Last) <u>Frank</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>9</u> (Year) <u>19 51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3-9-'31</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>20</u> yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William A. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Russell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Minnie Frye-Silver Cross Home</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
340.3 Immediate cause (a) <u>Epilepsy</u>			8 yrs.
Antecedent cause(s) (b) <u>Deaf & Dumb Mute</u>			18 yrs.
85 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Meningitis</u>			18 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>not an injury</u>

22. I hereby certify that I attended the deceased from 6-21, 1949, to 3-9, 1951, that I last saw the deceased alive on 3-9, 1951, and that death occurred at 12:35a am, from the causes and on the date stated above.

SIGNATURE (Degree or title) D. D. Caples ADDRESS Reisterstown, Md. DATE SIGNED 3-9-'51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>	LOCATION (City, town, or county) <u>E. North Ave</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>3-12-51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>John J. Bowman & Son</u>	ADDRESS <u>Rolling</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02313

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Academy Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Academy Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>341 GREENLOW ROAD</u>		STREET ADDRESS (If rural, give location) <u>341 GREENLOW Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>J.</u>	(Last) <u>GERMERSHAUSEN</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>5</u>	(Year) <u>1951</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2-11-1894</u>
9. AGE last birthday <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TICKET AGENT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GERMERSHAUSEN</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE Schene</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>717-07-9521</u>	
17. INFORMANT AND ADDRESS <u>MRS. ANNA GERMERSHAUSEN - 341 Greenlow Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Pulmonary edema, acute

INTERVAL BETWEEN ONSET AND DEATH

2 mos.

Antecedent cause(s)

(b)

Hypertensive CVD, cardiac decomp, grade IVyears

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

Myocardial Infarction3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1950, to March 5, 1951, that I last saw the deceasedalive on March 5, 1951, and that death occurred at 4:45 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James J. Nelson MD5804 Edmundson Ave Ball, Md 3/5/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF
3-8-51NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEM.

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/7/51A W HednerTHOMAS J. KENNY, INC 1600 TOWNS ST

380506

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5804 *Sumner*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02314

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Vienna</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hospital</u>		STREET ADDRESS <u>Box 22</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>JAMES</u> (Middle) <u>E.</u> (Last) <u>GILES</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-3-78</u>
9. AGE last birthday <u>73</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
12. FATHER'S NAME <u>James L. Giles</u>		13. MOTHER'S MAIDEN NAME <u>Hanna Smith</u>	
14. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes</u> <u>SAW</u>		15. SOCIAL SECURITY No. <u>218-16-9408</u>	
16. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

527.1 Immediate cause (a) Failure, right ventricle and auricle (Cor. Pulmonale) Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pulmonary emphysema Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that VA attended the deceased from Feb. 7, 1951, to Mar. 3, 1951, ~~that I last saw the deceased~~~~XXXXXX~~ and that death occurred at 12:05 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

SAMUEL R. PINES, M.D. VAN FT. HOWARD, MD.

3-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
--	-------------------------------	--	--	---------

DATE REC'D. BY LOCAL REG. <u>3/5/51</u>	REGISTRAR'S SIGNATURE <u>A W [Signature]</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blight</u>	ADDRESS <u>6009 Harford Rd., Baltimore, Md.</u>
--	---	--	--

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Sparrow Point</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrow Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrow Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sparrow Point</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. 10, Box 375</u>	
3. NAME OF DECEASED (Type or Print) <u>John S Goldman</u>		4. DATE OF DEATH <u>3/14/1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 1, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	9. AGE last birthday <u>57</u> yrs.
13. FATHER'S NAME <u>Frank Goldman</u>		11. BIRTHPLACE (State or foreign country) <u>Hampton Sidney Virginia U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
16. SOCIAL SECURITY No. <u>219-05-9701</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Evans</u>	
17. INFORMANT <u>Rosa Goldman Sparrow Point Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>			<u>10 days</u>
Antecedent cause(s) (b) <u>Hypertension Cardio Vascular Disease</u>			<u>2 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>93d</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 14, 1951, to Mar 14, 1951, that I last saw the deceased alive on Mar 14, 1951, and that death occurred at 9:55 P.m., from the causes and on the date stated above.

SIGNATURE James J. Means M.D. ADDRESS 5202 St. Sparrow Pt 19 Md. DATE SIGNED 3/15/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/18/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Meroy Seat Cem.</u>	LOCATION (City, town, or county) <u>Farmersville Va</u>
DATE REC'D BY LOCAL REG. <u>3-16-51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedych</u>	24. FUNERAL DIRECTOR <u>Elroy O. Wilson 1000 Brantly ave</u>	

690336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02316

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt. City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Restonstown</u>		LENGTH OF STAY on this place <u>15 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Int. Pleasant Sanatorium</u>				STREET ADDRESS (If rural give location) <u>2423 Keyworth Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Paul</u>		(First) (Middle) (Last) <u>Doety</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 27 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 21, 1885</u>	9. AGE last birthday <u>65</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Lewis Doety</u>		14. MOTHER'S MAIDEN NAME <u>Ester Sussman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>578-03-3333</u>		17. INFORMANT <u>Hannah Doety (wife)</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>In myocardial failure</u>			
(b) Antecedent cause(s) <u>Cerebral Hemorrhage</u>			<u>6 months</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Diabetes Mellitus</u>			<u>6 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary Tuberculosis</u>			<u>4 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 25, 1949, to March 27, 1951, that I last saw the deceased alive on March 27, 1951, and that death occurred at 3 55 p.m., from the causes and on the date stated above.

SIGNATURE E. Proctor M.D. Int. Pleasant Sanatorium DATE SIGNED March 27 1951

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>3/28/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Windsor Hill Rd</u>	LOCATION (City, town, or county) <u>Balt</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3/28/51</u>	REGISTRAR'S SIGNATURE <u>H.W. Radnich</u>	24. FUNERAL DIRECTOR <u>Int. Lewis Inc</u>	ADDRESS <u>2100 Euteria Pl</u> <u>490656</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02317

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MIDDLE RIVER</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>IVY HALL NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>62 TOWNSHIP</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>WILSON</u>	(Last) <u>GRADWELL</u>
4. DATE OF DEATH	(Month) <u>MAR.</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2/22/1894</u>
9. AGE last birthday <u>57</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>PENNA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>ADAM WILSON</u>	
14. MOTHER'S MAIDEN NAME <u>MARY PATTERSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY No. <u></u>		17. INFORMANT <u>Charles A. Gradwell</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

170X Antecedent cause(s)
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Generalized metastatic carcinoma

(b) Carcinoma left breast

(c)

INTERVAL BETWEEN ONSET AND DEATH

8 mo

7 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>July 6 1944</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma, left breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1951, to March 18 1951, that I last saw the deceased

alive on March 11, 1951, and that death occurred at 7:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph P. Kelly M.D. 422 Eastern Ave Balto. 21 3/18/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. PK.</u>	LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
DATE REC'D BY LOCAL REG. <u>March 20 1951</u>	REGISTRAR'S SIGNATURE <u>William M. Kelly</u>	24. FUNERAL DIRECTOR <u>Walter Brock Beatty</u>	ADDRESS <u>Dundalk, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

CHIEF

RECEIVED
MAR 22 1951
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02318

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>aa</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>74 Cathedral St.</u>	
3. NAME OF DECEASED (Type or Print) <u>MURTHEN</u> (First) <u>(NMI)</u> (Middle) <u>GROSS</u> (Last)		4. DATE OF DEATH <u>Mar. 1</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-10-93</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm helper</u>	
11. BIRTHPLACE (State or foreign country) <u>West River, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Gross</u>		14. MOTHER'S MAIDEN NAME <u>Mary Colts</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>215-01-9606</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec., Vets. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN

451X Immediate cause

(a) ANEURYSM OF AORTA, CAUSE UNKNOWN

96 Antecedent cause(s)

(b) None

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF injury bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY
m.INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that VA attended the deceased from Dec. 30, 1950, to Mar. 1, 1951, and that death occurred at 7:12 Pm., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

JOSEPH M. MILLER, M. D., CHIEF, SURGICAL SERVICE, VAH, FORT HOWARD, MD. 3-2-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

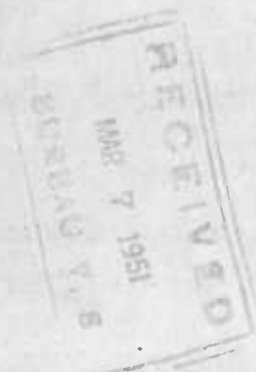
ADDRESS

Mar. 2, 1951Lawson ParkerWm. Reese Mortuary 108 Washington St.Annapolis, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 7 shown on:

MANO. G 131 APR 2 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02319

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) 2404 E. Lafayette Avenue	
3. NAME OF DECEASED (Type or Print) EDWARD		4. DATE OF DEATH (Month) March (Day) 19 (Year) 51	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify) Separated		8. DATE OF BIRTH June 3, 1864	
9. AGE last birthday 86 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME Frank Guard		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Hospital Records, Catonsville 28, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Cardiac decompensation, chronic			
Antecedent cause(s) (b) Arteriosclerotic cardio-vascular disease			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bilateral senile cataracts			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 15, 1951 , to Mar. 19, 1951 , that I last saw the deceased alive on Mar. 19, 1951 , and that death occurred at 9:45 a.m. , from the causes and on the date stated above.			
SIGNATURE Florence Virginia Joyce		DATE SIGNED 3-19-51	
(Degree or title) M.D. Catonsville 28, Maryland		ADDRESS Spring Grove State Hospital	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3/22/51	
NAME OF CEMETERY OR CREMATORY Balto.		LOCATION (City, town, or county) Balto. Md.	
24. FUNERAL DIRECTOR Wm Cook Inc 1217 St. Paul St.		ADDRESS 564246	
DATE REC'D BY LOCAL REG. 3/20/51		REGISTRAR'S SIGNATURE a w Hedrick	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Calonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Calonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 Helray Ave.</u>		STREET ADDRESS (If rural, give location) <u>29 Helray Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>IDA</u> (Middle) <u>HAMMEL</u> (Last) <u>HAMMEL</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>Apr. 4 1869</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT Country <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carle</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Fred C. Hammel, New York N.Y.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) -(c) -

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1949, to March 24, 1951, that I last saw the deceasedalive on March 24, 1951, and that death occurred at 12:25 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. J. G. Gura, 1 Mallon Hill Ave, Baltimore, Md.3/26/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/26/51V E. HarryW. Mac Mahon & Son
Calonsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

REC-114
MAR 29 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02321

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balts.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River (Acres Acres)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Fenway South. Rindale Apts.</u>		STREET ADDRESS (If rural, give location) <u>20 Fenway South (Rindale Apts.)</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ellen</u> (Middle) <u>J.</u> (Last) <u>Hansen</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>13</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 18-1876</u>
9. AGE last birthday <u>74</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>J. H. Harkins</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No.	17. INFORMANT <u>Robert Hansen, Middle River</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Immediate cause (a) <u>Cerebral hemorrhage.</u>	<u>20 hours</u>
Antecedent cause(s) (b) <u>Hypertensive arteriosclerosis C.V.D.</u>		<u>7 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 2, 1950, to March 13, 1951, that I last saw the deceased alive on March 12, 1951, and that death occurred at 8:40 a.m., from the causes and on the date stated above.

SIGNATURE Joseph Shear M.D. ADDRESS 805 Fawcett Ave Balto #20 Md. 3/13/51 DATE SIGNED 3/13/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>3/16/51</u>	<u>Oak Lawn</u>	<u>Eastern Ave. Balto and</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-13-51</u>	<u>[Signature]</u>	<u>John G. Connelly</u>	<u>Essex</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

805 Fuselage Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02322

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Houston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Houston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN - McLELLAN - HARE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 1 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 6 - 1882</u>
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Philip H Hare</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wilhelm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Leary Hare - Parkton Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Gangrene of lf. foot1 week(c) Chronic Arthritis20 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 12, 1951, to Feb 27, 1951, that I last saw the deceased alive on Feb 27, 1951, and that death occurred at 12 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 2/51</u>	<u>Houston</u>	<u>Balto</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-2-51</u>	<u>Mary B. Zline</u>	<u>Edw E Dutton</u>	<u>Hampstead</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 6 1961
U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02323

FILM No. G 101 MAR 30 1951 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Steuarn Balt</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balt</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>109th</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Steuarn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Carlos</u> (First) <u>Benedict</u> (Middle) <u>Harris</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3/16/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>12 years</u> If under 1 year Months <u>7</u> Days <u>24</u> Hours <u>24</u> Min.
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Robert Harris</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Agnes Williams</u> <u>4426 St. Guy</u> <u>4426 St. Guy</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH
26 1/2 hrs

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/16, 1951, to 3/17, 1951, that I last saw the deceased

alive on 3/16, 1951, and that death occurred at 9:45 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 18-1951</u>	<u>Int. City</u>	<u>Baltimore</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Mar 18-51</u>	<u>C. E. Arthur</u>	<u>C. E. Arthur</u>	<u>4426 St. Guy</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02324
Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>507 Old Home Rd.</u>		STREET ADDRESS (If rural, give location) <u>507 Old Home Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Ethel M. Heidel</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>14</u> , (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 8, 1896</u>
9. AGE last birthday <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Butcher</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Chas. Wilson 507 Old Home Rd.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis</u>				<u>2 days</u>	
Antecedent cause(s) (b) <u>Hypertension</u>				<u>3 yrs</u>	
(c) <u>Diabetes</u>				<u>5 yrs</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE) <u>Baltimore Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 13 1951</u> , to <u>March 14 1951</u> , that I last saw the deceased alive on <u>March 13 1951</u> , and that death occurred at <u>3:30 P.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Coral Gordon M.D.</u>		(Degree or title)		ADDRESS <u>300 E. North Ave</u>	
DATE SIGNED <u>3-14-51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/17/51</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	
LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>					
DATE REC'D BY LOCAL REG. <u>3-15-51</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	
				ADDRESS <u>2700 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02325

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 414 N. East Avenue	
3. NAME OF DECEASED (Type or Print)	(First) CHARLES	(Middle) F.	(Last) HEIDERICH
4. DATE OF DEATH	(Month) March	(Day) 12	(Year) 19 51
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-27-96
9. AGE last birthday 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Heiderich		14. MOTHER'S MAIDEN NAME Mamie Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443x Immediate cause (a) CEREBRAL THROMBOSIS, BILATERAL, RECENT & RECURRENT			3 1/2 years
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) HYPERTENSIVE CARDIOVASCULAR DISEASE			9 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 11, 19 51 , to March 12, 19 51 , and that death occurred at 9:04 A. m. , from the causes and on the date stated above.			
SIGNATURE Irving Freeman		ADDRESS VAH, FORT HOWARD, MD.	
DATE SIGNED 3-12-51			
23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/15/51	NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR J. J. MORAN FUNERAL HOME	ADDRESS Baltimore, Maryland		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *pe* 02326 *XX*

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 2554 Francis Street	
3. NAME OF DECEASED (Type or Print) JAMES (First) (NMI) (Middle) HERNDON (Last)		4. DATE OF DEATH (Month) March (Day) 25 (Year) 19 51	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-27-23
9. AGE last birthday 27 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Herndon		14. MOTHER'S MAIDEN NAME Laura Newman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Pulmonary Tuberculosis**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

unknown

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that **VA** attended the deceased from **March 15, 19 51**, to **March 25, 19 51**, and that the deceased

WALTER R. BENSON and that death occurred at **8:00 P.m.**, from the causes and on the date stated above.

SIGNATURE
WALTER R. BENSON, M.D.

(Degree or title)

ADDRESS

VAH, Fort Howard, Md.

DATE SIGNED

3-26-51

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Mar. 29, 19 51	NAME OF CEMETERY OR CREMATORY Baltimore, National	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG 3/27/51		REGISTRAR'S SIGNATURE AW Hedrick		24. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. Baltimore, Md	

DM

9700W

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02327

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rosedale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rosedale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1022 Chesco Ave.</u>		STREET ADDRESS (If rural, give location) <u>1022 Chesco Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Anna</u>	<u>Eva</u>	<u>Hessler</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 8 - 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10h. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>-</u>	
13. FATHER'S NAME <u>Hassner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hassner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. James L. Wilkie daughter</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Arteriosclerotic Cardio-vascular renal disease</u>		<u>2 yrs.</u>
Antecedent cause(s) (b) <u>442X 131a</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>no</u>	19h. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1st, 1949, to March 26, 1951, that I last saw the deceased alive on March 26, 1951, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

SIGNATURE James F. White M.D. ADDRESS 422 Eastern Ave., Baltimore 21-22 Md DATE SIGNED 3/29/51

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/29/51</u>	<u>Sacred Heart</u>	<u>German Hill Rd md.</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/29/51</u>	<u>R.W. Hedrich</u>	<u>John W. Connelly</u>	<u>East 21-nd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

The correct age in 18 shown on: EVIDENCE FOR CHANGE IN 18 SHOWN ON: PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly. is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02328

CERTIFICATE OF DEATH

Reg. Dist. No. 38

FAM No. G 131 MAR 27 1951

1. PLACE OF DEATH - COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MD COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 MURDOCK ROAD		STREET ADDRESS (If rural, give location) 17 MURDOCK ROAD	
3. NAME OF DECEASED (Type or Print)	(First) MARY	(Middle) EDNA	(Last) HUNTER
4. DATE OF DEATH	(Month) 3	(Day) 11	(Year) 1951
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-25-1882
9. AGE last birthday 69 yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME JOHN CAST		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY No. (If yes, give war or dates of service)	
17. INFORMANT AND ADDRESS ALBERT P. HUNTER		18. SAME	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Coronary occlusion**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Myocardial insufficiency**(c) **Arteriosclerotic hypertensive heart disease**

(underlying cause - 3-22-51 - ans)

INTERVAL BETWEEN ONSET AND DEATH

1 year

5 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11 Jan 51	19b. MAJOR FINDINGS OF OPERATION Cystocele and rectocele	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **20 June, 1950**, to **11 Mar., 1951**, that I last saw the deceasedalive on **1 Mar., 1951**, and that death occurred at **5:30 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 3-14-1951	NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL	LOCATION (City, town, or county) BALTO.	(State) MD.
DATE REC'D BY LOCAL REG. 3/13/51	REGISTRAR'S SIGNATURE G. W. Hedrick	24. FUNERAL DIRECTOR H.W. JENKINS & SONS Co.	ADDRESS 4905 YORK RD.	

DR. J. W. BARNABY
1531 E. NORTH AVE.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8641 Oakleigh Ave.</u>		STREET ADDRESS (If rural, give location) <u>8641 Oakleigh Ave.</u>			
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>DELLA M. JACKSON</u>					<u>March 31, 1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 24, 1898</u>	9. AGE last birthday <u>52</u> yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John W. Stigle</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Mr Ernest C. Jackson, 8641 Oakleigh Ave.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

420.0

Antecedent cause(s)

1247b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary arteriosclerotic heart disease & thrombosis 2 years

(b) Cirrhosis of the liver 2 years

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from January 5, 1951, to March 31, 1951, that I last saw the deceased alive on March 31, 1951, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Western</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/3/51</u>	REGISTRAR'S SIGNATURE <u>a w Hedner</u>	24. FUNERAL DIRECTOR <u>M. Cook Inc</u>	ADDRESS <u>1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02330

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>26 Winters Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Catonsville</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>26 Winters Ave</u> OR TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) <u>Jerry</u> (Middle) <u>Jackson</u> (Last) <u>Jackson</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>7</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Baby</u>	8. DATE OF BIRTH <u>Sept 3, 1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. <u>6</u> Months <u>6</u> Days <u>7</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Engine Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Harnett Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Harnett Jackson</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Broncho-Pneumonia</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>?</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-4, 1951, to 3-7, 1951, that I last saw the deceased alive on 3-7, 1951, and that death occurred at 5:45 A m., from the causes and on the date stated above.

SIGNATURE <u>E. J. Maloney</u>		ADDRESS <u>57 Winters Ave Balto-28</u>		DATE SIGNED <u>Mar 7/57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March</u>	NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	LOCATION (City, town, or county) <u>Howard Co.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>3/9/57</u>	REGISTRAR'S SIGNATURE <u>A W H</u>	24. FUNERAL DIRECTOR <u>Mrs Katie R. Williams</u>		ADDRESS <u>Schroeder St</u>

209030264393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19149

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02331

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> TOWN <u>Fort Howard</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>24</u> STREET ADDRESS (If rural, give location) <u>2710 Elliott St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Boleau JAKUBOUSKI or Boleslaw JAKUBOWSKI</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 3 1951</u>	
5. SEX <u>MALE</u> <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-9-96</u>
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Jakubowski</u>		14. MOTHER'S MAIDEN NAME <u>Josephine ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>219-10-3331</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Thrombosis

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 3, 1951, to Mar. 3, 1951, that I last saw the deceasedalive on and that death occurred at 4:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

SAMUEL R. PINES, M.D. VETERANS ADMINISTRATION FORT HOWARD, MD.

5-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>7 Mar. 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>3-5-51</u>	REGISTRAR'S SIGNATURE <u>W. Redman</u>	24. FUNERAL DIRECTOR ADDRESS <u>Stephen J. Fialkowski 1000 S Kenwood Ave.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290636

THE UNIVERSITY OF MICHIGAN LIBRARY

ANN ARBOR, MICHIGAN

02332

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		Fort Howard		LENGTH OF STAY (in this place)		6 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR		Baltimore 6	
TOWN		Fort Howard		TOWN		Baltimore 6		STREET ADDRESS		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS		4100 Mary Avenue					
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
JAMES		L.		JENKINS		March 12		19 51			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year Months Days Hours Mln.	
Male		White		Married		11-17-96		54 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Bus Driver		Transit Bus Co.		Hayns, Ark.		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
James Lee Jenkins		Elizabeth Stanfield									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS							
yes		213-05-9327		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4343 Immediate cause	(a) CARDIAC DILATATION AND HYPERTROPHY		2 YEARS +
131 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u>	(b) NONE		
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. CHRONIC GLOMERULONEPHRITIS			UNKNOWN
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While st Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that VA attended the deceased from March 6, 1951, to March 12, 1951, [REDACTED] the deceased.

~~State of New York~~ and that death occurred at 10:06 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<i>[Signature]</i>			

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND 3-13-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>3-14-51</u>	REGISTRAR'S SIGNATURE <u>aw Hedrick</u>	24. FUNERAL DIRECTOR <u>Howard Blight Funeral Home</u>	ADDRESS <u>6009 Harford Road, Baltimore 11, Maryland</u> <u>Mildred J. Blight 625-516</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02333

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>135 Fleming Drive</u>		STREET ADDRESS (If rural, give location) <u>135 Fleming Drive</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>KINSLER</u>	(Last) <u>JOHNSON</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>13</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-29-96</u>
9. AGE last birthday <u>54</u> yrs.	If under 1 year Months <u>3</u> Days <u>14</u>	If under 24 hrs. Hours <u>14</u> Mins. <u>14</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Fairfield, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>UNITED STATES</u>
13. FATHER'S NAME <u>Adam Kinsler</u>	14. MOTHER'S MAIDEN NAME <u>Eliza Macarilly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)
16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT AND ADDRESS <u>Mr. Henry Johnson 135 Fleming Drive</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Respiratory Failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>45 MINS</u>
Antecedent cause(s) (b) <u>Right Lobar Pneumonia (Lower Lobe)</u>	<u>4 days</u>
(c) _____	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE <u>None</u> HOMICIDE <u>None</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at <input type="checkbox"/> Nat. While <input type="checkbox"/> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JANUARY 5, 1951, to MARCH 13, 1951, that I last saw the deceased alive on MARCH 13, 1951, and that death occurred at 12:55 P.M. from the causes and on the date stated above.

SIGNATURE <u>William C. Dale M.D.</u>	(Degree or title)	ADDRESS <u>140 Oak Avenue, Dundalk 22, Md.</u>	DATE SIGNED <u>MARCH 13, 1951</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	LOCATION (City, town, or county) (State) <u>Chester, S.C.</u>
DATE REC'D BY LOCAL REG <u>3-15-57</u>	REGISTRAR'S SIGNATURE <u>Arw Hedrick</u>	24. FUNERAL DIRECTOR <u>Charles R. Law</u>	ADDRESS <u>802 Madison Ave.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02334

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorp</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Halethorp Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>206I North East Avenue</u>		STREET ADDRESS (If rural, give location) <u>206I North East Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Sarah</u>			<u>Johnson</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 13. 84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Susan Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Bessie Saterwhittle 206I North East a</u>	
17. INFORMANT <u>Avenue</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331x Immediate cause (a) <u>Thrombocytopenia, Cerebral Hemorrhage</u>		
83a Antecedent cause(s) (b) <u>Hypertension</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 19, 1951., to Mar 4, 1951., that I last saw the deceased alive on Mar 3, 1951., and that death occurred at 1 A.M., from the causes and on the date stated above.

SIGNATURE Thos. Kennedy M.D. ADDRESS Edridge 27 Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/8/1951</u>	<u>Mt Arburn</u>	<u>Baltimore</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/7/51</u>	<u>A.W. Kennedy</u>	<u>Elroy O. Wilson</u>	<u>1000 Brantley Ave</u>	

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wayne Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>317 Park Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY E. JORDAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 8, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 21, 1872</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Michael K. Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Amelia J. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>J. Frank Kelly, 317 Park Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of the Stomach</u>		<u>1 1/2 yrs</u>
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to March, 1951, that I last saw the deceased alive on March 4, 1951, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE Morris W. Steinberg M.D. ADDRESS 410 N. Hilton St DATE SIGNED April 9, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>March 10, 1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>W. R. ...</u>	ADDRESS <u>1219 St Paul St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02336

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville (Rural)</u> TOWN <u>Beekleyville (Rural)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville (Rural)</u> TOWN <u>Beekleyville (Rural)</u> STREET ADDRESS	
3. NAME OF DECEASED (First) <u>MARY</u> (Middle) <u>ELLEN</u> (Last) <u>KELLEX</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>July 19-1868</u>
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George W. Potts</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr Horace Kelley, Hampstead Md</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute Coronary Occlusion</u>	<u>3 hrs</u>
420.1 Antecedent cause(s) (b) <u>Chronic Coronary Vascular Disease</u>	<u>?</u>
932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Ch. Myocarditis</u>	<u>-</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN) <u>Hampstead Md</u>	(COUNTY) <u>MD</u> (STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-19-51</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3-19, 1951, to 3-19, 1951, that I last saw the deceased alive on 3-19, 1951, and that death occurred at 11 P. m., from the causes and on the date stated above.

SIGNATURE <u>Joseph E. Bush M.D.</u>	ADDRESS <u>Hampstead Md</u>	DATE SIGNED <u>3/20/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Black Rock</u>
LOCATION (City, town, or county) <u>Balto co Md</u>	(State) <u>MD</u>	
DATE REC'D BY LOCAL REG. <u>3-21-51</u>	REGISTRAR'S SIGNATURE <u>Clayton E. Line</u>	24. FUNERAL DIRECTOR <u>Edw. C. Tipton</u>
		ADDRESS <u>Hampstead Md</u>

RECEIVED
JUN 28 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02337

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Relay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Linthicum Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>413 W. Forest View Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Fulton</u>	(Middle) <u>Guy</u>	(Last) <u>Kelly</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	4. DATE OF DEATH (Month) (Day) (Year) <u>March 5 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Constable (Retd.)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>County Comm.</u>	8. DATE OF BIRTH <u>Dec 4 1893</u>	9. AGE last birthday <u>57 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Fulton Kelly</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wife - Mrs. Cord E. Kelly</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Coronary Heart Disease with Congestive Failure</u>	<u>1 week</u>
420.0 Antecedent cause(s)	(b) <u>Bronchopneumonia</u>	<u>22 hrs.</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 4, 1951, to Mar 5, 1951, that I last saw the deceased alive on Mar 5, 1951, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/8/51</u>	<u>Friendship</u>	<u>Friendship, Md</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/6/51</u>	<u>A. W. Redman</u>	<u>Wm. J. Dickner & Sons</u>	<u>771 936 Balto, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02338

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Spring Grove State Hospital Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Calvert	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Huntingtown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural, give location) Huntingtown, Maryland	
3. NAME OF DECEASED (Type or Print) Charles (First) (Middle) (Last) Kent		4. DATE OF DEATH (Month) (Day) (Year) March 24 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Sept. 29, 1863 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Father Retired printer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year Months Days Hours Min. 87
11. BIRTHPLACE (State or foreign country) Calvert County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. Yates Kent		14. MOTHER'S MAIDEN NAME Bret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs. Florence K. Harris, Argonne Apt. #221, 1629 Columbia Rd NW, Washington, D.C.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis	INTERVAL BETWEEN ONSET AND DEATH
420.0 Antecedent cause(s) (b) Arteriosclerotic Heart Disease with circulatory failure	unknown
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on **March 24**, 1951, and that death occurred at **7:00 A.M.**, from the causes and on the date stated above.SIGNATURE **Albert A. Kurland MD** ADDRESS **Spring Grove State Hospital Catonsville, MD.** DATE SIGNED **March 24/51**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF 3-27-51	NAME OF CEMETERY OR CREMATORY all Saints Cem.	LOCATION (City, town, or county) (State) Severland, Md.
DATE REC'D BY LOCAL REG. 3/25/51	REGISTRAR'S SIGNATURE T. E. Harry	24. FUNERAL DIRECTOR Wm. J. Dickner & Sons	ADDRESS 512 VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 26 1951
BUREAU 7.2

MARGIN RESERVED FOR BINDING
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.				CERTIFICATE OF DEATH				Registered No. <u>43</u>			
1. NAME OF DECEASED (Type or Print) <u>Anna M. Klein</u>				2. DATE OF DEATH <u>3/8/51</u>				02339			
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. Co. Md</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>							
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>8025 Belair Rd.</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Bellerton</u>							
c. Length of stay in Baltimore <u>life</u>				D. STREET ADDRESS (If rural, give location) <u>8025 Belair Rd.</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/2/79</u>		9. AGE (In years last birthday) <u>72</u>		If Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>				11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brockmeyer</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Fitch</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Mr. Geo A. Klein</u>			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>443x</u>				CAUSE OF DEATH (A) <u>Pulmonary Edema</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>93d</u>				(B) <u>Cardio-Vascular Hypertension</u> DUE TO				<u>7 years</u>			
(C) <u>Arteriosclerosis</u>								<u>7 years</u>			
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>March 8</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 8</u> , 19 <u>51</u> , and that death occurred at <u>10:35 P. m.</u> , from the causes and on the date stated above.											
23A. SIGNATURE <u>Michael J. Dausch</u>				23B. ADDRESS M. D. <u>4636 Belair Road</u>				23C. DATE SIGNED <u>3/8/51</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/12/51</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parson's Wood</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. City Md.</u>					
DATE RECEIVED BY LOCAL REGISTRAR <u>3/9/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>				25. FUNERAL DIRECTOR <u>Abraham Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>			

MEDICAL CERTIFICATION

Additions of #10 & 11
Information taken
from the undertaker.
4/2/51 jt.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02340

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Essex		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN 1629 Gail Rd. Essex	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Barbara Klein		4. DATE OF DEATH March 22 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct 7 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 73 yrs.
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Welch		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No.	
17. INFORMANT Marie Senft			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Acute pulmonary edema		15 Mins.
Antecedent cause(s) (b)	Coronary insufficiency		?
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	Coronary sclerosis		?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/20, 1951, to 3/22, 1951, that I last saw the deceased alive on 3/20, 1951, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE D. Day Black, M.D. ADDRESS 434 Eastern Ave. Essex 21, Md. DATE SIGNED 2/22/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE March 24 1951	NAME OF CEMETERY OR CREMATORY Mt. Carmel	LOCATION (City, town, or county) (State) Baltimore Md.
DATE REC'D BY LOCAL REG. March 23, 1951	REGISTRAR'S SIGNATURE <u>E. H. Hurley</u>	24. FUNERAL DIRECTOR John E. Goff	ADDRESS Chase Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

or 9710

ms 1 line



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

be 02341

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson, Md.</u> LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson, Md.</u> <i>uncl. Balto.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Presbyterian Home</u>		STREET ADDRESS (If rural give location) <u>Presbyterian Home</u> <i>uncl. ✓</i>	
3. NAME OF DECEASED (First) <u>Laura</u> (Middle) <u>Knellinger</u> (Last) _____	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1951</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 25, 1858</u>
9. AGE last birthday <u>92</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George Knellinger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bush</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY No. _____	
17. INFORMANT <u>Records - Presbyterian Home, Towson, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492X Immediate cause

(a) Pneumonia - atypical -

INTERVAL BETWEEN ONSET AND DEATH

2 wks.

109 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐ (STATE)

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar 6, 1951, to Mar 17, 1951, that I last saw the deceased

alive on Mar 17, 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE John S. Green Jr. M.D. ADDRESS Allegheny Ave., Towson, Md. DATE SIGNED 3/19/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3 - 20 - 51</u>	<u>Parkwood</u>	<u>Baltimore County, Md.</u>	

DATE REC'D BY LOCAL REG. <u>3/20/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Bedwick</u>	24. FUNERAL DIRECTOR <u>John O. Mitchell & Sons, Inc.</u>	ADDRESS <u>1900 Butaw Place</u>
---	--	---	---------------------------------

Baltimore, Md.
M.B. Mitchell 633448

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02342

1. PLACE OF DEATH - COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>So</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>2600 W. Fairmont Avenue</u>	
3. NAME OF DECEASED (First) <u>MARY</u> (Middle) <u>A. Manouse,</u> (Last) <u>KOSTOPOULOS</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>5</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January 20, 1896</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Constantinople, Greece</u>
13. FATHER'S NAME <u>Antoion Christogonides</u>		14. MOTHER'S MAIDEN NAME <u>Maria (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital Records, Catonsville 28, Maryland</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic glomerular nephritis with uremia</u>			
Antecedent cause(s) (b) <u>Hypertensive cardiovascular disease</u>			
(c) <u>Chronic heart failure</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 29, 1950, to March 5, 1951, that I last saw the deceased alive on March 5, 1951, and that death occurred at 11:40 p.m., from the causes and on the date stated above.			
SIGNATURE <u>Flora Berina, Jr. M.D.</u>		ADDRESS <u>Spring Grove St. Hosp.</u>	DATE SIGNED <u>3-6-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-8-51</u>	NAME OF CEMETERY OR CREMATORY <u>Greek Cemetery</u>	LOCATION (City, town, or county) (State) <u>Windsor Mill Rd.</u>
DATE REC'D BY LOCAL REG. <u>3-8-51</u>	REGISTRAR'S SIGNATURE <u>L</u>	24. FUNERAL DIRECTOR <u>Lambros Inc.</u>	ADDRESS <u>440 E. North Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02343

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>New Jersey</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard, Md.</u> LENGTH OF STAY (in this place) <u>45 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Camden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>2028 Broadway</u>	
3. NAME OF DECEASED (First) <u>CHARLES</u> (Middle) <u>L.</u> (Last) <u>KRAUSE</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>10</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-23-96</u>
9. AGE last birthday <u>54</u> yrs.		10. AGE last birthday (If under 1 year) Months <u>1</u> Days <u>10</u> Hours <u>19</u> Min. <u>51</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	
14. FATHER'S NAME <u>Charles Krause</u>		15. MOTHER'S MAIDEN NAME <u>Catherine Gruber</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1941-1</u>		17. SOCIAL SECURITY No. <u>unknown</u>	
18. INFORMANT AND ADDRESS <u>Clinical Record Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of right kidney</u>	<u>8 months plus</u>
Antecedent cause(s) (b) <u>180x 52a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) (Minute) <u>OF INJURY</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 24, 1951, to Mar. 10, 1951, that I last saw the deceased alive on 10-23-96, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) ADDRESS VA. HOSPITAL, FT. HOWARD, MD. DATE SIGNED 3-11-51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	DATE THEREOF <u>3-11-51</u>	NAME OF CEMETERY OR CREMATORY <u>Ship to 30th Street Station, Phila. c/o Antonia Decca, 619 South 4th St.</u>	LOCATION (City, town, or county) (State) <u>Camden, N.J.</u>
DATE REC'D BY LOCAL REG. <u>3-12-51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Mildred Blight 6009 Harford Rd. Balto. Md.</u>	ADDRESS <u>763 W. Medred T. Blight, 6009 Harford Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1029 W. Barre Street	
3. NAME OF DECEASED (First) VINCENT (Middle) H. (Last) KRERIVIENAS		4. DATE OF DEATH (Month) March (Day) 8 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-5-94
9. AGE last birthday 56 yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor (Unemployed)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Henry Krerivienas		14. MOTHER'S MAIDEN NAME Frances MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY No. 216-05-6992	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause

(a) **CARDIAC DECOMPENSATION**

1 YEAR

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

UNKNOWN

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

UREMIA

UNKNOWN

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) HOMICIDE	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **March 5, 1951**, to **March 8, 1951**, that I saw the deceasedand that death occurred at **10:00 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND**3-9-51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/13/51	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) Baltimore, Maryland	(State)
--	--------------------------------	--	--	---------

DATE REC'D BY LOCAL REG. 3-12-51	REGISTRAR'S SIGNATURE A. W. Kachauskas	24. FUNERAL DIRECTOR Charles W. Kachauskas	ADDRESS 703 McHenry Street
--	--	--	--------------------------------------

Baltimore 30, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. XX

02345

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>5508 Northwood Drive</u>	
3. NAME OF DECEASED (First) <u>RICHARD</u> (Middle) <u>V.</u> (Last) <u>LAMB</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-28-97</u>
9. AGE last birthday <u>53</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard B. Lamb</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) CARCINOMA RIGHT BRONCHUS

6 MONTHS +

Antecedent cause(s)

(b) DIABETES MELLITUS
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

6 MONTHS +

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 5, 1950, to March 28, 1951, and that death occurred at 9:23 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 3-28-51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/29/51Wm. J. Tickner & SonsNorth & Pa. AvenuesBaltimore, Maryland350 936Don

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4X

02346

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>District of Columbia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hosp., Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>764 Irving Street, N. W.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES C. LAWS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 26 19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-1-90</u>
9. AGE last birthday <u>61</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Raleigh, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Laws</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) BRONCHOGENIC CARCINOMA, LEFT

UNKNOWN

Antecedent cause(s)

(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that VA attended the deceased from Feb. 9, 1951, to March 26 1951, ~~and that the deceased~~and that death occurred at 11:25 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ACTING CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 3-27-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

SHIP TO: Lightner Funeral Home, 312 E. Smithfield Street, Raleigh, N. C. 773936

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1951

02347

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH - COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>Maryland</i> COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sparks, Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sparks, Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Belfort Rd - Rural</i>		STREET ADDRESS (If rural, give location) <i>Belfort Road</i>	
3. NAME OF DECEASED (Type or Print) <i>Sallic</i> (First) <i>Brenker</i> (Middle) <i>Lloyd</i> (Last)		DATE OF DEATH (Month) <i>MAR</i> (Day) <i>3</i> (Year) <i>1951</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>None</i>	8. DATE OF BIRTH (1890) <i>Feb 28, 1880</i> AGE last birthday <i>71</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Balto Co., Md</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give year or dates of service)		16. SOCIAL SECURITY No. <i>None</i>	17. INFORMANT AND ADDRESS <i>John E. Lloyd, Sparks, Md</i>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>Chronic myocarditis</i>			
(b) Antecedent cause(s) <i>arterio sclerosis</i>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, OF office hldg., etc.) <i>INJURY</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Sept.</i> , 19 <i>50</i> , to <i>Mar. 3</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>Mar. 2</i> , 19 <i>51</i> , and that death occurred at <i>5 a</i> m., from the causes and on the date stated above.			
SIGNATURE <i>E. M. France</i>		ADDRESS <i>M. D. Parkton, Md</i>	
DATE THEREOF <i>Mar. 5, 1951</i>		NAME OF CEMETERY OR CREMATORY <i>Cedar Grove</i>	
DATE REC'D BY LOCAL REG. <i>3/3/51</i>		24. FUNERAL DIRECTOR <i>London M. Brooks, Sparks, Md.</i>	
REGISTRAR'S SIGNATURE <i>W. J. Chilcoat</i>		LOCATION (City, town, or county) (State) <i>Putland Rd., Parkton, Md</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02348

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) Colgate		CITY (If outside corporate limits, write RURAL and give nearest town) Colgate - rural Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 511 Fairview Avenue		STREET ADDRESS (If rural, give location) 511 Fairview Avenue	
3. NAME OF DECEASED (Type or Print) (First) BARBARA (Middle) M. (Last) LUKEN		4. DATE OF DEATH (Month) March (Day) 26 (Year) 1951	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 7, 1872 78 yrs.
9. AGE last birthday 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hubner		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mrs. Russell Minnick		1695 Darley Avenue	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Diabetic Gangrene Left leg		1 month
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last Diabetes Mellitus		1 year
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/10, 1950, to 3/26, 1951, that I last saw the deceased alive on 3/25, 1951, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Joseph Pokorny M.D.

2200 E Madison St

3/27/51 Balt

23. BURIAL, CREMATION REMOVAL (Specify) burial	DATE THEREOF 3/29/51	NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 3/27/51	REGISTRAR'S SIGNATURE <i>HW Hedrick</i>	24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. BALTIMORE, MD.	
		ADDRESS <i>Queen Anne</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02349

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 Susquehanna Ave.</u>		STREET ADDRESS (If rural give location) <u>123 Susquehanna Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Florence Marie Lytle</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. RELIGION MARRIAGE <u>WIDOWED, DIVORCED.</u> (Specify)	8. DATE OF BIRTH <u>April 28, 1891</u>
9. AGE last birthday <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas J. Christopher</u>		14. MOTHER'S MAIDEN NAME <u>-</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Jack Lytle, 123 Susquehanna Ave.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Heart disease, valvular, mitral chronic with decompensation</u>		<u>10 yrs.</u>	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) <u>410X</u> <u>92b</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Bollin C. Hudson M.D., P.M.E.</u>		DATE SIGNED <u>3/15/51</u>	
23. BURIAL, Cremation (Specify)		NAME OF CEMETERY <u>Moreland Park</u>	
DATE REC'D BY LOCAL REG. <u>3-16-51</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 49

02350

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard, Md.</u> TOWN <u>Port Howard, Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>none</u>	
3. NAME OF DECEASED (First) <u>JOHN</u> (Type or Print)	(Middle) <u>F</u>	(Last) <u>MATES</u>	4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>3</u> (Year) <u>19 51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-6-96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed - janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>54</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Mates</u>		14. MOTHER'S MAIDEN NAME <u>Anna MN Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No. <u>213-07-0633</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Infarct

Antecedent cause(s)

(b) Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 mos.

unknown

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 26, 19 50, to Mar. 3, 19 51, that I last saw the deceased

alive on XXXXXX and that death occurred at 10:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. R. Pines
SAMUEL R. PINES, M.D. VAN FT. HOWARD, MD.

3-4-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-7-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>	LOCATION (City, town, or county) <u>5501 Frederick Ave. Balto. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3/5/51</u>	REGISTRAR'S SIGNATURE <u>a w Hedlund</u>	24. FUNERAL DIRECTOR <u>Moran Funeral Home 3000 E. Balto. St. Balto. Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

770000

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *41*

Balts. Co. 02351

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 7234 Martell Avenue	
3. NAME OF DECEASED (First) ARTHUR (Middle) N. (Last) MATTHEWS		4. DATE OF DEATH (Month) March (Day) 9 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10-9-95
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>	
11. BIRTHPLACE (State or foreign country) Blossburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James T. Matthews		14. MOTHER'S MAIDEN NAME Sarah Yarrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I&II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause CEREBRAL EDEMA		UNKNOWN
(b) Antecedent cause(s) MULTIPLE SCLEROSIS Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		20 YEARS
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that **I** attended the deceased from **Sept. 3, 1948**, to **March 9, 1951**, ~~and that death occurred at~~

March 12, 1951, and that death occurred at **11:15 A.m.**, from the causes and on the date stated above.

SIGNATURE <i>Paul Padget</i> PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND	(Degree or title)	ADDRESS Baltimore, Maryland	DATE SIGNED 3-9-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/13/51	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. March 12-1951	REGISTRAR'S SIGNATURE <i>William J. Kelly</i>	24. FUNERAL DIRECTOR Bradley Funeral Home, Inc. 700 Willow Spring Road, Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 13 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02352

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
TOWN <u>Catonsville</u> LENGTH OF STAY (in this place) <u>13 yrs.</u>		TOWN <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Oak Hill Road</u>		STREET ADDRESS (If rural, give location) <u>Oak Hill Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ELLA JOSEPHINE MAY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 29, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Nov. 2, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>81</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>New York</u>
13. FATHER'S NAME <u>Thomas Niles</u>	14. MOTHER'S MAIDEN NAME <u>Mary Benjamin</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> unknown) (If year, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY No. <u>None</u>	17. INFORMANT <u>Mrs. James E. Booth Catonsville Md.</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>
Immediate cause	(a) <u>Myocarditis (Pulmonary Edema)</u>		
157X Antecedent cause(s)	(b) <u>Carcinoma of Pancreas</u>		
469 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Hypertension - Arteriosclerosis</u>		<u>Jan. 14 51</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>4 years -</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1938, 19....., to March 29 1951, that I last saw the deceased alive on March 29, 1951, and that death occurred at 5-45 P m., from the causes and on the date stated above.

SIGNATURE <u>Wm. H. Jones, Jr.</u>	(Degree or title) <u>MD</u>	ADDRESS <u>20 S. Preston St. Baltimore 2 Md.</u>	DATE SIGNED <u>3/24/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE <u>3/31/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's Church</u>	LOCATION (City, town, or county) (State) <u>Spencertown N.Y.</u>
DATE REC'D BY LOCAL REG. <u>3/30/51</u>	REGISTRAR'S SIGNATURE <u>V. E. Barry</u>	24. FUNERAL DIRECTOR <u>Easton Sons</u>	ADDRESS <u>Catonsville Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 2 1961
BUREAU A. 2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02353

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH - COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MARYLAND COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) SPARROWS PT.		CITY (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2418 SP. PT. ROAD		STREET ADDRESS (If rural, give location) 2418 SP. PT. ROAD	
3. NAME OF DECEASED (Type or Print) OSCAR GEORGE (First) MAYER (Last)	4. DATE OF DEATH MARCH 26 (Month) 1951 (Year)		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 3/4/1890
9. AGE last birthday 61 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER	10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS	11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME Geo Meyer	14. MOTHER'S MAIDEN NAME Marie Luchs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Geo. O. Mayer 2418 SP. PT. RD	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from **Dec 15, 1950**, to **March 24, 1951**; that I last saw the deceased alive on **March 24, 1951**, and that death occurred at **12:45 a.m.**, from the causes and on the date stated above.

SIGNATURE: **Dr. J. D. Smith**

(Degree or title)

ADDRESS **520 28th St. SpR**DATE SIGNED **3-26-51**

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF **3/29/51**NAME OF CEMETERY OR CREMATORY **Lanier Beach**LOCATION (City, town, or county) **Balto Co**

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE **R. W. Hedrick**

24. FUNERAL DIRECTOR

ADDRESS **2112 Dundalk**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

580416

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02354

Reg. Dist. No. 36

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Grant</u> (Last) <u>Mays</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 30, 1865</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckster</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Produce Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Wesley Mays</u>	
14. MOTHER'S MAIDEN NAME <u>Ethel M. Mays</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <u>Grant Mays Jr.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cardio - Vascular renal disease</u>			
Antecedent cause(s) (b) <u>442X Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19 <u>45</u> , to <u>Mar 10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar 9</u> , 19 <u>51</u> , and that death occurred at <u>10:45 P</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>G. M. France</u>		DATE SIGNED <u>3/11/51</u>	
23. BURIAL OR CREMATION RECEIVED (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Hereford Baptist</u>	
DATE REC'D BY LOCAL REG. <u>3/12/51</u>		24. FUNERAL DIRECTOR <u>James H. Anderson, New York</u>	

RECEIVED
MAY 21 1951
U.S. AIR FORCE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltheorpe</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>West Blvd</u>		STREET ADDRESS (If rural, give location) <u>608 E. 31st St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert A. McAllister</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 30 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>9/23/1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat Shore & Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter & Mill</u>	9. AGE last birthday <u>30</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto. md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Edgar McAllister</u>		14. MOTHER'S MAIDEN NAME <u>Nelen Blakely</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>608 E. 31st St.</u>	
17. INFORMANT <u>Sara R. McAllister</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute cardiac failure</u> Antecedent cause(s) (b) <u>Coronary vascular disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Dr. M. Kieffer</u>		ADDRESS <u>6010 Leesdaan</u>	
DATE SIGNED <u>Mar 31 51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/2/51</u>	
NAME OF CEMETERY OR CREMATORY <u>U. S. National</u>		LOCATION (City, town, or county) (State) <u>Balto. md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 31 51</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc. 1217 St. Paul St.</u>	
REGISTRAR'S SIGNATURE <u>Dr. Kieffer</u>		ADDRESS	

502246

RECEIVED
APR 2 1961
R. B. B. & S.

7-8 P.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02355

CERTIFICATE OF DEATH

Reg. Dist. No. 38

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Linganore Ave</u>		STREET ADDRESS (If rural, give location) <u>16 Linganore Ave</u>			
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
	<u>CLARA</u>	<u>LOUISE</u>	<u>McDONALD</u>	<u>Mar. 17, 1951</u>	<u>19</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 14, 1885</u>	9. AGE last birthday <u>65</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Gustav A. Bomaser</u>			14. MOTHER'S MAIDEN NAME <u>Virginia Mathews</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Edward R. McDonald, 6720 Sherwood Ave.</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>420.1</u> <u>94a</u>	(a) <u>Coronary Thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>" Sclerosis</u>	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 40, 1940 to 3-17, 1951, that I last saw the deceased

alive on 3-15, 1951, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE C. W. Peake ADDRESS M. P. 4508 Hanford Rd. Balt. 14 DATE SIGNED 3-19-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Western</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>3/20/51</u>	REGISTRAR'S SIGNATURE <u>a w Hedrick</u>	24. FUNERAL DIRECTOR <u>M. P. 4508 Hanford Rd. Balt. 14</u>	ADDRESS <u>1214 S. Con St</u>

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02356

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN McDonogh		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN McDonogh	
HOSPITAL OR INSTITUTION OR STREET ADDRESS McDonogh School Infirmary		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) John	(First)	(Middle) Summerville	(Last) Medairy
4. DATE OF DEATH March 3rd	(Month)	(Day)	(Year) 1967
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Jan. 26, 1860
9. AGE last birthday 91 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired General Agent		10b. KIND OF BUSINESS OR INDUSTRY Railway Express-Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME -----Medairy		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Roland Brady, 3910 Milford Rd.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

10 yrs.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec**, 19**67**, to **Mar 2**, 19**67**, that I last saw the deceased

alive on **2 Mar**, 19**67**, and that death occurred at **1:00 P.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. **3/5/67**

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

290506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02357

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balta</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>411 Delaware Ave</u>		STREET ADDRESS <u>411 Delaware Ave</u>	
3. NAME OF DECEASED (First) <u>Theodore</u> (Middle) <u>B</u> (Last) <u>Merling</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>9</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17-1885</u>
9. AGE last birthday <u>65</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Frank Merling</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Margaret Merling</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420-1 Immediate cause (a) <u>Coronary Occlusion</u>			
94a Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>		SIGNATURE <u>Dr. J. J. Davis</u> (Degree or title) ADDRESS <u>100 N. ...</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/12/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-12-51</u>		REGISTRAR'S SIGNATURE <u>W. W. Radtch</u>	
24. FUNERAL DIRECTOR <u>John D. Connelly</u>		ADDRESS <u>Essex, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02358

Reg. Dist. No. 45

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chase Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bird River Rd</u>				STREET ADDRESS (If rural, give location) <u>Bird River Rd #85</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Mary</u> (Middle) <u>A</u> (Last) <u>Messenger</u>		4. DATE OF DEATH		(Month) <u>March</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Apr. 12-1890</u>	9. AGE last birthday <u>60 yrs.</u>	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Co</u>	
13. FATHER'S NAME <u>Jos. Euxice</u>				14. MOTHER'S MAIDEN NAME <u>Eliz. Winkler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Mr. WM. Messenger Bird River Rd. #85</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Cerebro-Vascular accident</u>						<u>1 wk</u>	
(b) Antecedent cause(s) <u>Arteriosclerotic Cardio-Vascular disease</u>						<u>10 yrs</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 1, 1951</u> to <u>March 10, 1951</u> , that I last saw the deceased alive on <u>March 10, 1951</u> , and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.							
SIGNATURE <u>W. B. Cunningham M.D. Balto 6 Md</u>				DATE SIGNED <u>3-10-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/14/51</u>		NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem</u>		LOCATION (City, town, or county) (State) <u>Balto Co md</u>	
DATE REC'D BY LOCAL REG. <u>3/12/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7401 Blain Rd.</u>			

Dr. Baumgardner

MARYLAND STATE DEPARTMENT OF HEALTH

02359

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 32

1. PLACE OF DEATH— COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>mt. Wilson</u> TOWN <u>mt. Wilson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>mt. Wilson</u>		MARYLAND LENGTH OF STAY (In this place) <u>20 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>mt. Wilson</u> TOWN <u>mt. Wilson</u> STREET ADDRESS (If rural, give location) <u>mt. Wilson Road</u>	
3. NAME OF DECEASED (First) <u>Henry</u> (Middle) <u>Meyer</u> (Last) <u>Meyer</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>8</u> (Year) <u>1951</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan - 21 - 1886</u>	9. AGE last birthday <u>85</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>night watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mt. Wilson, Md</u>		11. BIRTHPLACE (State or foreign country) <u>Ordendorf, Germany</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT <u>Robert Seigermann, mt. Wilson Sanatorium</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Suicide by hanging</u>	INTERVAL BETWEEN ONSET AND DEATH <u>approx.</u>
Antecedent cause(s) (b) <u>164a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	<u>2 hrs.</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>None</u>	(CITY OR TOWN) <u>None</u> (COUNTY) <u>None</u> (STATE) <u>None</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Not an injury</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE D. D. Caples Deputy Med. Exam. M.D. ADDRESS Reisterstown, Md. DATE SIGNED 3-8-'51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>3/10/51</u>	NAME OF CEMETERY OR CREMATORY <u>Gruef Ridge</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>3-9-51</u>	REGISTRAR'S SIGNATURE <u>J. E. E. Nichols</u>	24. FUNERAL DIRECTOR <u>Frank H. Jewell, Pikesville, Md.</u>	ADDRESS <u>763869</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02360

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>417 5th Ave</u>		STREET ADDRESS (If rural, give location) <u>417 5th Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herman</u> (Middle) <u>Meyer.</u> (Last) <u>Meyer.</u>	4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>23-</u> (Year) <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid.</u>	8. DATE OF BIRTH <u>Sept. 16-1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>87</u> yrs. If under 1 year: Months <u>23-</u> Days <u>23-</u> Hours <u>23-</u> Mln. <u>23-</u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Heinrich Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Laura ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Berda Meyer 417. 5th Ave Lansdowne Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Apoplexy

Immediate cause

(a)

Antecedent cause(s)

Hypertensive cardiovascular disease

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

General arteriosclerosis

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

16 days

About 3 Yrs.

" "

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 8, 1951, to March 23, 1951, that I last saw the deceasedalive on March 23, 1951, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Wood/awn</u>	LOCATION (City, town, or county) <u>Wood/awn Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3/26/51</u>		REGISTRAR'S SIGNATURE <u>R.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc. 1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02361

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fork</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sunshine Ave. 40th St. Polley</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balt. City</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>1300 S. Hanover St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Alfred</u> (Middle) <u>E</u> (Last) <u>Meyett</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 19 - 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Meyett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Tayman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy (service) 1929-1934</u>		16. SOCIAL SECURITY NO. <u>216-03-8713</u>	
17. INFORMANT <u>Mary Meyett Polley (sister)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>442x</u> <u>Cardio-renal disease with decompensation</u>		<u>2 yrs.</u>	
(b) <u>Antecedent cause(s)</u> <u>121a</u> <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Other significant conditions</u> <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Rollin B. Hudson M.D., D.M.E. Towson, Md.</u>		DATE SIGNED <u>3/11/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar 14 - 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Stephens Cem.</u>		LOCATION (City, town, or county) <u>Broadshaw Md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 12 - 51</u>		24. FUNERAL DIRECTOR <u>G. E. Arthur D. Ford</u> ADDRESS <u>Fork Md.</u>	

683 568

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC-11
JUN 12 1961
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02362

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middlebrough Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middlebrough Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Wye Rd. Rt 16</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Joseph</u>	<u>L</u>	<u>Michael</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
<u>M.</u>	<u>W.</u>	<u>married</u>	<u>Nov 21-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Carpenter</u>		<u>Construction</u>	<u>67</u> yrs.
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
<u>John Michael</u>		<u>Balto. Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT
<u>yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		<u>220-01-4003</u>	<u>Florence Michael</u>

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Coronary Occlusion</u>	<u>2 hrs</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertensive Cardio-vascular disease</u>	<u>7 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 1948, to....., 19March 30, 51, that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Joseph Michael MD 422 Eastern Ave 3/31/51
Balto. Co. 21, Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Buried</u>	<u>4/3/51</u>	<u>Balto Natl Cemetery</u>	<u>Balto Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-2-51</u>	<u>A.W. Hedrick</u>	<u>J. J. Buzdunski</u>	<u>1407 Eastern Ave</u> <u>510246</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7818 Old Harford Rd.</u>		STREET ADDRESS (If rural, give location) <u>7818 Old Harford Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>D.</u>	(Last) <u>MICHEL</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>1</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 26, 1889</u>
9. AGE last birthday <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Representative Customs Office - Gas & Elec.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Conrad Michel</u>	
14. MOTHER'S MAIDEN NAME <u>Cecelia Stroup</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-05-3058</u>		17. INFORMANT AND ADDRESS <u>Mrs. Mary E. Michel - 7818 Old Harford Rd.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Antecedent cause(s)

(b)

Hypertensive cardio-vascular disease, arteriosclerosis 10 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Chronic myocarditis c 2nd degree decompensation

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Emphysema of chest, obesity

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 17, 1950, to March 1, 1951, that I last saw the deceasedalive on Feb 26, 1951, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. V. Harbold M.D.4706 Harford Road - 143/2/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

3-5-51H. W. HedrickThos. J. Sicker & Son - Balto390588md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

Baltimore Co.
02364

1. PLACE OF DEATH COUNTY <i>Parkville</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Parkville</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3033 Putty Hill Ave.</i>		STREET ADDRESS (If rural, give location) <i>3033 Putty Hill Ave.</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Archie</i> (Middle) <i>M.</i> (Last) <i>Miller</i>	4. DATE OF DEATH (Month) <i>Mar.</i> (Day) <i>7</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 27-1865</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday (If under 1 year) <i>86</i> yrs. (Months) (Days) (Hours) (Min.)
11. BIRTH PLACE (State or foreign country) <i>Baltimore Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Peter Biltz</i>		14. MOTHER'S MAIDEN NAME <i>Martha Bauers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Mr. John P. Miller - 3033 Putty Hill</i>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Cerebral Thrombosis</i>			<i>3 wks</i>
Antecedent cause(s) (b) <i>Generalized Arteriosclerosis</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Diabetes mellitus</i>			<i>7 yrs</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *July 23*, 19*45*, to *March 7*, 19*51*, that I last saw the deceased alive on *March 7*, 19*51*, and that death occurred at *7:00 A*. m., from the causes and on the date stated above.

SIGNATURE *James M. D.* (Degree or title) ADDRESS *6217 Harford Rd* DATE SIGNED *3/7/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>3/10/51</i>	NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
DATE REC'D BY LOCAL REG. <i>3/7/51</i>	REGISTRAR'S SIGNATURE <i>A W Hedrick</i>	24. FUNERAL DIRECTOR <i>H. J. Luck</i>	ADDRESS <i>5305 Harford Rd.</i>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Alessi

The correct age
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

#'s 8 & 9

Evidence shown on Film

0132 4/5/51 jt.

Affidavit of son.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02365

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Edmondson Ave. and North Bond Hood Nursing Home				STREET ADDRESS 214 Washington Avenue		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) SARAH		(First) AGNES		(Last) MILLER		4. DATE OF DEATH March 22, 1951	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH May 3, 1882/1882	
						9. AGE last birthday 69 yrs. 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitoress		10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Bldgs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John O'Donovan				14. MOTHER'S MAIDEN NAME Mary Quinn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Family Records			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Peracute Hemorrhagic

331x

Antecedent cause(s)

(b)

Acute to Sclerotic

83a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
SUICIDE		INJURY							
HOMICIDE									
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?					
OF		While at		Not White					
INJURY		m. Work		At work <input type="checkbox"/>					

22. I hereby certify that I attended the deceased from 3-20, 1951, to 3-22, 1951, that I last saw the deceased alive on 3-21, 1951, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Mar. 24, 1951		NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		LOCATION (City, town, or county) Texas, Balto. Co., Maryland		(State)	
DATE REC'D BY LOCAL REG. 3/23/51		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
		John E. Harry		John Burns' Sons, Towson, Maryland					

770 936

RECEIVED
MAR 28 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02366

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
TOWN <u>Overlea</u>		TOWN <u>Overlea</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Fullerton Heights Ave</u>		STREET ADDRESS (If rural, give location) <u>10 Fullerton Heights Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>S. J.</u> (Last) <u>Moore</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>18</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 2, 1878</u>
9. AGE last birthday <u>72</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Watchman Retired American Oil Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Moore</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Max</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-4818</u>	
17. INFORMANT AND ADDRESS <u>Julia K. Moore 10 Fullerton Heights Ave</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary atherosclerosis</u>				
Antecedent cause(s) (b) <u>Arteriosclerosis</u>				
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>				
II. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 1, 1951, to 3/18, 1951, that I last saw the deceased alive on 3/18, 1951, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

SIGNATURE C. J. Melito ADDRESS 1279 Belham St DATE SIGNED 3/19/51

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>MAR 21 1951</u>	NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>	LOCATION (City, town, or county) <u>4430 BELAIR RD MD.</u>
DATE REC'D BY LOCAL REG. <u>3/20/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Shippel Bros</u>	ADDRESS <u>7110 BELAIR RD.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

763476

Dr. Whittle

1379 Williams St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

02367

1. PLACE OF DEATH COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville - 28</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
TOWN <u>4 1/2 yrs</u>		TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>612 N. Curley St</u>	
3. NAME OF DECEASED (Type or Print) <u>FREDERICK</u> (First) <u>MORAN</u> (Middle) (Last)		4. DATE OF DEATH <u>3-18-1957</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-29-1886</u> (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Isam Fire Dept</u>	
13. FATHER'S NAME <u>John Moran</u>		14. MOTHER'S M maiden name <u>Bertha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Hosp. Records.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Occlusion</u>		<u>1 mo.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis C.V. disease</u>		<u>15 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Osteomyelitis left femur</u>		<u>25 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

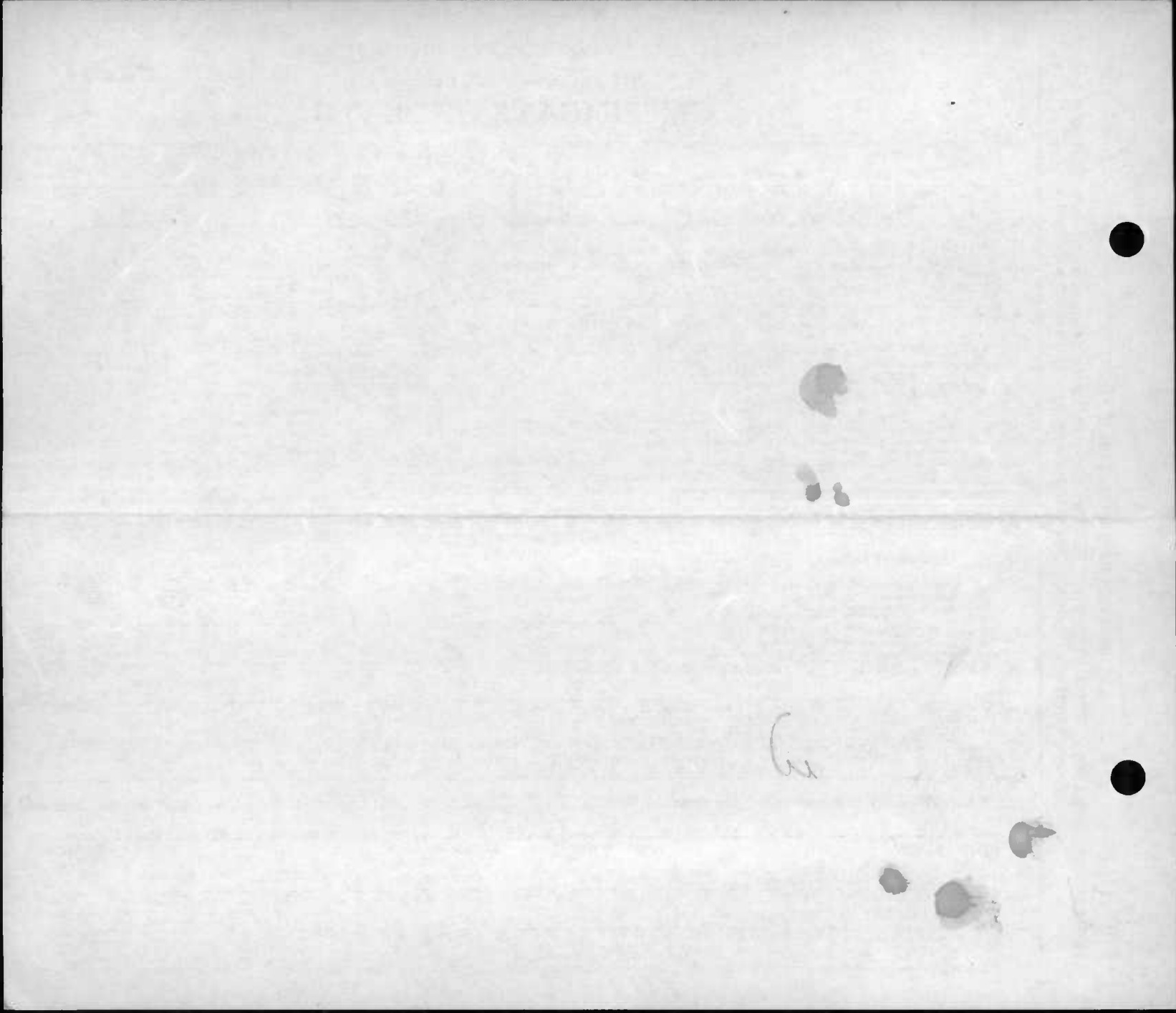
22. I hereby certify that I attended the deceased from 7-1, 1950, to 3-18, 1957, that I last saw the deceased alive on 3-17, 1957, and that death occurred at 6:10 P m., from the causes and on the date stated above.

SIGNATURE <u>Florence Deranger Joyce and</u>		ADDRESS <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>3-18-57</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>March 25-57</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Carmel</u>	LOCATION (City, town, or county) <u>Baltimore</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3/19/57</u>	REGISTRAR'S SIGNATURE <u>A W Hedrick</u>	24. FUNERAL DIRECTOR <u>Edmund W. Wynn</u>	ADDRESS <u>5118 S. Dufferin Oak Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02368

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>106 VENTNOR TERRACE</u>		STREET ADDRESS (If rural give location) <u>106 VENTNOR TERRACE</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES</u> (First) <u>R.</u> (Middle) <u>O'CONNELL</u> (Last)		4. DATE OF DEATH (Month) <u>MAR.</u> (Day) <u>6</u> (Year) <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 27, 1896</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>F. V. GOLDSBOROUGH</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES O'CONNELL</u>		14. MOTHER'S MAIDEN NAME <u>CATHARINE FLANIGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u>		16. SOCIAL SECURITY No. <u>212-01-6444</u>	
17. INFORMANT <u>CATHARINE M. O'CONNELL, 106 VENTNOR TER.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Coronary Occlusion</u>			
2. Immediate cause (a) <u>420.1</u> Antecedent cause(s) (b) <u>94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>Dr. J. J. Davis</u> (Degree or title) ADDRESS <u>Dundalk, Md.</u> DATE SIGNED <u>3/6/57</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3. 9. 57</u>	
NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
DATE REC'D BY LOCAL REG. <u>3/7/57</u>		REGISTRAR'S SIGNATURE <u>A. W. Redus</u>	
24. FUNERAL DIRECTOR <u>John E. Mully</u>		ADDRESS <u>2425 E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02369

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore Co.,</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Church Lane</u>		STREET ADDRESS (If rural, give location) <u>105 Church Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John B. O'Neill</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 2, 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 25, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore Transit Co</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Foreman</u>	9. AGE last birthday <u>72</u> yrs.
13. FATHER'S NAME <u>Thomas O'Neill</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Bloss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. John B. O'Neill (wife)</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>Sudden</u>
420.1 Antecedent cause(s) (b) <u>Chronic Stomach & Liver disease</u>			<u>?</u>
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Shingles</u>			<u>3 mos</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-20, 1950, to 3-2, 1951, that I last saw the deceased alive on Feb 2, 1951, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

<u>E. E. Nichols</u>		<u>md</u>		<u>1402 Reisterstown Rd.-8</u>		<u>2-2-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)			
<u>Burial</u>	<u>2/5/51</u>	<u>Druid Ridge Cemetery</u>	<u>Pikesville, Md.</u>				
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS			
<u>2-2-51</u>	<u>E. E. Nichols</u>	<u>H. W. Measorson</u>		<u>805 N. Calvert St.</u>			

523-516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 5 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 45

02370

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bowleys Quarters -20</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bowleys Quarters -</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>328 E. Bay Drive Road</u>		STREET ADDRESS (If rural, give location) <u>328 E. Bay Drive Road -20</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSE</u> (First) <u>PADGETT</u> (Last)		4. DATE OF DEATH <u>March 21, 1951</u> (Month) (Day) (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 26, 1895</u>
9. AGE last birthday <u>55</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>East Orange, N.J.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. L. Erbeck</u>		14. MOTHER'S MAIDEN NAME <u>Louise Wischmeyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-14-3540</u>	
17. INFORMANT AND ADDRESS <u>328 E. Bay Drive Rd</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174x Immediate cause (a) Cancer of uterus

48x Antecedent cause(s) (b) none

(c)

INTERVAL BETWEEN ONSET AND DEATH

8 months11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.none

19a. DATE OF OPERATION <u>Aug. 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of uterus</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 10, 1950, to March 21, 1951, that I last saw the deceased alive on March 20, 1951, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/23/51</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>3/22/51</u>		REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>		ADDRESS <u>BALTO., 13, MD</u>	

320897

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

02371

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Wilson, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Dundalk, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital		STREET ADDRESS (If rural, give location) 3120 Shortway	
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) George	(Last) Palmer
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/31/1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Shipyard	9. AGE last birthday 49 yrs. If under 1 year Months 1 Days 29 If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Warren Co., Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Palmer		14. MOTHER'S MAIDEN NAME Mary Wiggins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS James G. Palmer, 3120 Shortway Dundalk, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Far Advanced Pulmonary Tuberculosis**

INTERVAL BETWEEN ONSET AND DEATH

About 5 yrs.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify)

SUICIDE

HOMICIDE

None

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4/9**, 19**48**, to **3/29**, 19**51**, that I last saw the deceasedalive on **3/29**, 19**51**, and that death occurred at **2:45** a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William H. Weaver**M.D.****Mt. Wilson, Md.****3/29/51**

23. BURIAL, CREMATION REMOVAL (Specify)

Removal

DATE THEREOF

3/29/51

NAME OF CEMETERY OR CREMATORY

Zoro Meth. Church Cemetery

LOCATION (City, town, or county)

Warren Co.

(State)

Ga.

DATE REC'D BY LOCAL REG.

3/29/51

REGISTRAR'S SIGNATURE

Nolan R. Mayer

24. FUNERAL DIRECTOR

Wm. Cook

ADDRESS

1215 St. Paul St. Baltimore, Md.

544378

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02372

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>North Side of Apt. 36 off Fenway South</u>		STREET ADDRESS (If rural, give location) <u>5 Byway South, Apt. B</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>THELMA</u> <u>PARKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>1</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Oct 20-1906</u>
9. AGE last birthday <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Benton Parker</u>		14. MOTHER'S MAIDEN NAME <u>S. Caroline Curlee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>237-10-0411</u>	
17. INFORMANT <u>J. Pearl Parker</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

- 983x Immediate cause (a) Asphyxia due to manual strangulation
- 168 Antecedent cause(s) (b) Multiple contusions and abrasions of head
- (c) Subarachnoid and subdural hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Street</u>		CITY OR TOWN <u>North side of Apt. 36 off Fenway South Middle River, Baltimore County, Md.</u>		COUNTY <u>Baltimore</u>		STATE <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/1/51</u> <u>1:15 A. m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Beaten and strangled</u>					

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>3-2-51</u>		NAME OF CEMETERY OR CREMATORY <u>Wadesboro, North Carolina</u>		LOCATION (City, town, or county) (State) <u>Wadesboro, North Carolina</u>	
DATE REC'D BY LOCAL REG. <u>3-2-51</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>John J. Connelly - 418 Eastern Ave</u>		ADDRESS <u>544377 Balto 21, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) Deale	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) ALVIN	(Middle) O.	(Last) PHIPPS
4. DATE OF DEATH	(Month) March	(Day) 5	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-18-95
9. AGE last birthday 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman (unemployed)	
11. BIRTHPLACE (State or foreign country) Churchton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Phipps		14. MOTHER'S MAIDEN NAME Nellie Randall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CEREBRAL HEMORRHAGE**

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

(b) **HYPERTENSIVE CARDIOVASCULAR DISEASE**

15 years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **March 2, 1951**, to **March 5, 1951**

and that death occurred at **9:15 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND

3-6-51

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/8/51	NAME OF CEMETERY OR CREMATORY Woodfields Cemetery	LOCATION (City, town, or county) Gallesville, Maryland	(State)
---	-------------------------------	---	--	---------

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 6-51 Dawson L. Harber

Bernard Hardesty Gallesville, Maryland

910126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 9 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02374

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Anne Arundel Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Butler Road</u>		STREET ADDRESS (If rural, give location) <u>209 Arundel Road</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Alice Owens Randall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Mch. 14 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 26, 1873</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Hank Owens</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wilson Peak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>C. C. Speed-108 Butler Rd., Glyndon, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Gastric Hemorrhage</u>		<u>30 mins.</u>
Antecedent cause(s) (b) <u>Metastatic Carcinoma</u>		<u>5 yrs.</u>
(c) <u>Carcinoma of Left breast</u>		<u>10 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>April 1940</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left breast</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>No</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Not an injury</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

A. D. Caples, Dep. Med. Exam.

M. D. Reisterstown, Md.

3-14-'51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/16/51</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-16-51</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Pickner</u>	24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons - Balto. Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Van Ruse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **30**

02375

1. PLACE OF DEATH COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) Calverville TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Nood Nursing home		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Balti CITY (If outside corporate limits, write RURAL and give nearest town) Arbutus TOWN STREET ADDRESS 4202 Maryland Place (If rural give location)	
3. NAME OF DECEASED (Type or Print) BARBARA	(First) CRISTINA	(Last) RAUSCH	4. DATE OF DEATH (Month) March (Day) 4 (Year) 1951
5. SEX Female	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 27, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Conrad Wengert		14. MOTHER'S MAIDEN NAME unknown.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY No. no	
17. INFORMANT Margaret Muller			

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Cerebro-vascular accident		4 days
(b) Antecedent cause(s) Hypertension		years
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none		
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) none SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) none INJURY	(CITY OR TOWN) none (COUNTY) none
TIME (Month) (Day) (Year) (Hour) OF INJURY none m.	INJURY OCCURRED While at At home Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from **1 March, 1951**, to **4 March 1951**, that I last saw the deceased alive on **4 March, 1951**, and that death occurred at **2:20 P.** m., from the causes and on the date stated above.

SIGNATURE **William Goodman** (Degree or title) **M.D.** ADDRESS **1334 Sulphur Spring Rd.** DATE SIGNED **4 Mar 51**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/8/51	NAME OF CEMETERY OR CREMATORY Lorraine Pk Cem.	LOCATION (City, town, or county) Dogwood Rd. Md.
DATE REC'D BY LOCAL REG. 3/5/51	REGISTRAR'S SIGNATURE A W Hedrick	24. FUNERAL DIRECTOR John J. Towne & Son	ADDRESS 20 Rolling St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Be 02376
3
Reg. Dist. No.

CERTIFICATE OF DEATH

FILM No. G 131 APR 2 1951

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Bal to Ctiy</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>since 8-28-48</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>		STREET ADDRESS (If rural, give location) <u>Seton Inst.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>A.</u> (Middle) <u>RHEIN</u> (Last)		4. DATE OF DEATH <u>March 27</u> (Month) (Day) <u>1951</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>1885 June 5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs. <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George RHEIN</u>		14. MOTHER'S MAIDEN NAME <u>Katherine THERALF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If year, give war or dates of service)</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hospital records</u> <u>Spring Grove Hospital, Catonsville-28, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443x Immediate cause (a) <u>Left and right heart failure</u>		<u>7 days</u>
Antecedent cause(s) (b) <u>Hypertensive c. v. dis. with arteriosclerosis</u>		<u>indef.</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 28, 1948, to March 27, 1951, that I last saw the deceased alive on March 27, 1951, and that death occurred at 4:30 A m., from the causes and on the date stated above.

SIGNATURE Abraham M. Schneidmuhl, M. D. ADDRESS Spring Grove Hospital, Catonsville DATE SIGNED March 27, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Italy Redeemer</u>	LOCATION (City, town, or county) <u>Balto Md</u>	(State)
DATE RECD BY LOCAL REG. <u>3/27/51</u>	REGISTRAR'S SIGNATURE <u>R.W. Ruck</u>	24. FUNERAL DIRECTOR <u>S. J. Ruck</u>	ADDRESS <u>5305 Harford Rd</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02377

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Long Beach		CITY (If outside corporate limits, write RURAL and give nearest town) Long Beach, Middle River	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) Route 15, Box 196 B Balto., 20, Md.	
3. NAME OF DECEASED (First) Lorena	(Middle) Mead	(Last) Riggs	4. DATE OF DEATH (Month) March (Day) 12 (Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Sept. 13, 1863
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE last birthday 87 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Gettysburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Tipton		14. MOTHER'S MAIDEN NAME ? Kitzmiller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT Oran D. Riggs, Route 15 Box 196 B Balto. 20, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151x Immediate cause
46b Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) **Carcinoma of Stomach**

INTERVAL BETWEEN ONSET AND DEATH

2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct 1st**, 19**50**, to **March 12**, 19**51**, that I last saw the deceased

alive on **March 12 1951**, and that death occurred at **7:00 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-14-51

Edw Hedrich

Charles S. Geiler

901 S. Conkling St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02378

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH COUNTY <i>Baltimore</i> (19) STATE <i>MARYLAND</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sparks Pt.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>in</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2822 Lodge Farm Rd.</i>		STREET ADDRESS (If rural give location) <i># 1.</i>	
3. NAME OF DECEASED (Type or Print) <i>ARMESIA ARMELIA ROBERTS</i>		4. DATE OF DEATH (Month) <i>Mar</i> (Day) <i>16</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Sept 15, 1868</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE last birthday <i>82 yrs.</i>
11. BIRTHPLACE (State or foreign country) <i>Norfolk Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry White</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Bowser</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY No.	
17. INFORMANT <i>deceased</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Pulmonary edema*

INTERVAL BETWEEN ONSET AND DEATH
1 hour

422.1 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Arteriosclerosis + myocarditis*

10 years

(c) *Broncho Pneumonia*

4 days Sept

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

Adeno carcinoma rt breast with mastectomy '48

19a. DATE OF OPERATION <i>Sept. 1950</i>	19b. MAJOR FINDINGS OF OPERATION <i>adeno carcinoma breast (well healed)</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Mar 40*, 19*40*, to *Mar 16*, 19*51*, that I last saw the deceased

alive on *Mar 16*, 19*51*, and that death occurred at *3:30 P* m., from the causes and on the date stated above.

SIGNATURE <i>Louis N. Tallin</i>	(Degree or title)	ADDRESS <i>M. W. 6908 N. Bond Rd Batts - 19 Ma</i>	DATE SIGNED <i>3/16/51</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Mar. 20-51</i>	NAME OF CEMETERY OR CREMATORY <i>Folley Cem.</i>	LOCATION (City, town, or county) (State) <i>Norfolk Co. Va</i>
DATE REC'D BY LOCAL REG. <i>3/19/51</i>	REGISTRAR'S SIGNATURE <i>A. W. H. H. H.</i>	24. FUNERAL DIRECTOR <i>Samuel W. Sullivan</i>	ADDRESS <i>1011 N. Arlington Ave</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02379

Reg. Dist. No. 45

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>220 Poplar Rd.</u>		STREET ADDRESS (If rural, give location) <u>220 Poplar Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Herbert</u> (Middle) <u>W.</u> (Last) <u>Roberts</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>21</u> (Year) <u>19 51</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>D</u>	8. DATE OF BIRTH <u>9/12/1897</u>
9. AGE last birthday <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer - Boiler Room</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George C. Roberts</u>	
14. MOTHER'S MAIDEN NAME <u>Charlotte Young</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Charlotte Roberts 7621 Cypress St.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.2 Immediate cause (a) Chronic Myocarditis
 Antecedent cause(s) (b) 93d
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/22/51

A. W. Hedrich jt

Clarence F. Hoffman 1639 Broadway

680408

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02380

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hosp., Ft. Howard, Md.		STREET ADDRESS (If rural, give location) 1514 Madison Avenue	
3. NAME OF DECEASED (Type or Print) CORDELL		4. DATE OF DEATH (Month) (Day) (Year) March 6 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 7-6-19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fertilizer plant (unemployed)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 31 yrs.
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ora Rucker		14. MOTHER'S MAIDEN NAME Bessie M. Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 259-16-5520	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **PULMONARY HEMORRHAGE**

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 HOUR

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **PULMONARY TUBERCULOSIS, BILATERAL, FAR ADVANCED****1 YEAR****10 MONTHS**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **June 7, 1949**, to **March 6, 1951**, ~~and that death occurred at the residence of the deceased~~and that death occurred at **7:30 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IRVING FREEMAN, M. D., ASSISTANT CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MD. 3/9/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 3/13/51	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) Baltimore, Maryland	(State)
DATE REC'D BY LOCAL REG. 3-12-51	REGISTRAR'S SIGNATURE C. W. Hedrick	24. FUNERAL DIRECTOR Charles R. Law	ADDRESS 802 Madison Avenue Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02381

CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>W. Fullerton</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>W. Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>517 St Patrick Rd</u>				STREET ADDRESS (If rural, give location) <u>517 St Patrick Rd</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Frederick William Schaar</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 3 1951</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>6-22-1894</u>	
9. AGE last birthday <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker, Comptek Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE Md</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Alais Schaar</u>			
14. MOTHER'S MAIDEN NAME <u>Katherine Rimbach</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No.				17. INFORMANT <u>Mrs. Josephine E. Schaar 517 St. Patrick Rd</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Thrombosis, posterior</u>						<u>3 days</u>	
Antecedent cause(s) (b) <u>420.1</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>40</u> , to <u>3-3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>51</u> , and that death occurred at <u>745 P.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>William L. Henry M.D.</u>				ADDRESS <u>3025 Belair Rd</u>			
DATE SIGNED <u>3-5-51</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-6-1951</u>		<u>Landon Park</u>		<u>Balto Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/6/51</u>		<u>A. W. Henry</u>		<u>ELMER W. CONKLIN</u>		<u>924 E. EAGER ST.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *30**re 02382*

1. PLACE OF DEATH: COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Opitz Home</i>		STREET ADDRESS (If rural, give location) <i>2808 Riggs Avenue</i>	
3. NAME OF DECEASED (Type or Print) <i>Peter M. Schneider</i>		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>5</i> (Year) <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Jan. 6, 1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Transit Co.</i>	9. AGE last birthday <i>79</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-01-0210</i>	
17. INFORMANT AND ADDRESS <i>William E. Schaeffer 2808 Riggs Ave</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Myocardial Degeneration*

Antecedent cause(s)

(b) *Chromoma Lobar*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. *Smoking*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July*, 19*57*, to *March 5*, 19*57*, that I last saw the deceasedalive on *March 3*, 19*57*, and that death occurred at *5:10 p.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*57**970516*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02383

CERTIFICATE OF DEATH

Reg. Dist. No. *05*

1. PLACE OF DEATH COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Dundalk</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Dundalk</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>2918 Liberty Parkway</i>	
3. NAME OF DECEASED (Type or Print) <i>Herbert W. Schmitzer</i>		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>21</i> (Year) <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 15, 1905</i>
9. AGE last birthday <i>46</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Fredrick H. Schmitzer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Schmitz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-9742</i>	
17. INFORMANT <i>Mrs. Emma Schmitzer 2918 Liberty Pkwy</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause <i>Acute Coronary Thrombosis</i>	(a)	<i>1/2 hr.</i>
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <i>myocarditis, neuritis</i>	<i>3 mo.</i>
	(c) <i>Bone cyst - left little finger</i>	<i>3 mo.</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPTSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May 9, 1936* to *March 21, 1957*, that I last saw the deceased alive on *March 21, 1957*, and that death occurred at *11:05 PM* m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>buried</i>	DATE THEREOF <i>March 24, 1957</i>	NAME OF CEMETERY OR CREMATORY <i>Old Fellowship</i>	LOCATION (City, town, or county) <i>Dundalk</i>	(State) <i>MD</i>
DATE REC'D BY LOCAL REG. <i>3/22/57</i>	REGISTRAR'S SIGNATURE <i>A W. Hedger</i>	24. FUNERAL DIRECTOR <i>Ullrich Funeral Home</i>	ADDRESS <i>2004 Orleans</i>	

515246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02384

1. PLACE OF DEATH - COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Graceland Pk.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Graceland Pk.</u>	
TOWN <u>Graceland Pk.</u>		TOWN <u>Graceland Pk.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6734 Danville Ave</u>		STREET ADDRESS (If rural, give location) <u>6734 Danville Ave</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>A.</u> (Last) <u>Schutz</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>10</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 14, 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finishes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u> </u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY No. <u>215-05-1919</u>	
17. INFORMANT AND ADDRESS <u>Joseph Schutz 6734 Danville Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) CORONARY ARTERIO SCLEROSIS

94a Antecedent cause(s) (b) GENERALIZED ARTERIO SCLEROSIS

(c)

INTERVAL BETWEEN ONSET AND DEATH 2 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u> </u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u> </u>	(CITY OR TOWN) <u> </u>	(COUNTY) <u> </u>	(STATE) <u> </u>
SUICIDE <u> </u>	INJURY <u> </u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
HOMICIDE <u> </u>	INJURY OCCURRED While at <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>		
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m.				

22. I hereby certify that I attended the deceased from Sept 27, 1949, to Mar 10, 1951, that I last saw the deceased alive on Mar 10, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Mar 13-1951

NAME OF CEMETERY OR CREMATORY Sacred Heart

LOCATION (City, town, or county) Balto. Co.

(State) Md.

DATE REC'D BY LOCAL REG. 3-12-51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. S. Fialkowski 2007 Eastern Ave

670309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *38*

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and OR nearest town) <u>Baltimore</u> LENGTH OF STAY (in this place) <u>Life</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 12</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>104 Midhurst Rd.</u>				STREET ADDRESS (If rural, give location) <u>104 Midhurst Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EMILY JANE SEWARD</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 3, 1951</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>		8. DATE OF BIRTH <u>Dec. 11, 1866</u>	
9. AGE last birthday <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John J. Muckelroy</u>			
14. MOTHER'S MAIDEN NAME <u>Georganna Griffin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY No. <u>none</u>				17. INFORMANT AND ADDRESS <u>Mrs. J. Edward Thursby- 104 Midhurst Rd.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>General atherosclerosis</u>							
Antecedent cause(s) (b) <u>450.0</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>97</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>40</u> , to <u>Mar. 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar. 2</u> , 19 <u>51</u> , and that death occurred at <u>10a.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Wm. McKnight</u>				ADDRESS <u>701 N. Kenwood Ave.</u>		DATE SIGNED <u>3/5/51</u>	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>burial</u>		DATE TIME OF <u>3/6/51</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/5/51</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedden</u>		FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>		ADDRESS <u>BALTO., 13, MD.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02386

Reg. Dist. No. 35 ~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near White Hall 4 mas.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - White Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>West Liberty.</u>		STREET ADDRESS (If rural, give location) <u>West Liberty.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Chester Arthur Shaeffer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 20, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 6/1881</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trolley Car</u>	
11. BIRTHPLACE (State or foreign country) <u>Stewartstown, Pa.</u>		12. CITIZEN OR WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E. Shaeffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>336-07-9114</u>	
17. INFORMANT AND ADDRESS <u>Barfield Shaeffer - White Hall</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cerebral Hemorrhage</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arterio Sclerosis</u>			
(c) <u>Diabetes Condition</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/16</u> , 19 <u>51</u> , to <u>3/20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>51</u> , and that death occurred at <u>3:40 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James L. Yagle</u>		ADDRESS <u>New Freedom Pa</u>	
DATE SIGNED <u>3/22/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 23, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		LOCATION (City, town, or county) <u>White Hall, Md.</u>	
24. REGISTRAR'S SIGNATURE <u>James L. Yagle</u>		25. HUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>	
DATE REC'D BY LOCAL REG. <u>3/22/51</u>			

661516



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02387

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glyndon</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>226 Central Avenue</u>		STREET ADDRESS (If rural, give location) <u>226 Central Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>George</u>	(First) <u>W.</u> (Middle) <u>Siegrist</u> (Last)	4. DATE OF DEATH	(Month) <u>3-</u> (Day) <u>8-</u> (Year) <u>51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 26, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee Calvert Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal worker</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Siegrist</u>		14. MOTHER'S MAIDEN NAME <u>Mary Weise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>216-03-1122</u>	
17. INFORMANT <u>Mrs. Evelyn Welsh (niece)</u>		<u>Glyndon, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>1 wk.</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>2 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Not an injury</u>

22. I hereby certify that I attended the deceased from 3-4....., 1951., to 3-8....., 1951., that I last saw the deceased alive on 3-7....., 1951., and that death occurred at 4 p.m., from the causes and on the date stated above.

SIGNATURE D. D. Caples (Degree or title) ADDRESS M. D. Reisterstown, Md. DATE SIGNED Mch. 8, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>3-12-51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. ADDRESS <u>BALTIMORE - 13, MD.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02388

Reg. Dist. No. 93

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>BALTO CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 Delight Ave</u>		STREET ADDRESS (If rural, give location) <u>24 Delight Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Almer</u>	(Middle) <u>L</u>	(Last) <u>Smith</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>17</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb-21-1903</u>
9. AGE last birthday <u>48</u> yrs.	If under 1 year Months <u></u> Days <u></u>	If under 24 hrs. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Equipment</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Elect Co</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO CO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Bruce M. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ann M. Clayton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-09-9807</u>	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. A L Smith, 24 Delight Ave, BALTO MD</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>			<u>1 hr.</u>
Antecedent cause(s) (b) <u>420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>94a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>47</u> , to <u>Mar 17</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>51</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Adam J. Lewis</u>		DATE SIGNED <u>Mar 17, 1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/20/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Fox M. M. Cem</u>		LOCATION (City, town, or county) <u>BALTO MD</u>	
DATE REC'D BY LOCAL REG. <u>3/19/51</u>		24. FUNERAL DIRECTOR <u>Lassalle Funeral Home</u>	
REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		ADDRESS <u>7401 Balair Rd. BALTO MD</u>	

Dr. Swiss

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

02389

1. PLACE OF DEATH— COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklandville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklandville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Road</u>		STREET ADDRESS <u>Falls Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edward</u>	(Middle) <u>Carr</u>	(Last) <u>Smith</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 15, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>68</u> yrs.
13. FATHER'S NAME <u>John Smith</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>214-26-6654</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla Carr</u>	
17. INFORMANT AND ADDRESS <u>John Mumma Brooklandville, Maryland</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Carcinoma of stomach, liver and intestines</u>		about 1 year	
Antecedent cause(s)		(b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>June 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar 14, 1950, to Mar 16, 1951, that I last saw the deceased alive on Mar 15, 1951, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE E E Nichols (Degree or title) MD ADDRESS Pikesville, Md DATE SIGNED 3-17-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>March 19, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>
DATE REC'D BY LOCAL REG. <u>3-17-51</u>	REGISTRAR'S SIGNATURE <u>E E Nichols</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u> ADDRESS <u>3631 Falls Road</u>	

Horace F. Burgee 100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

EX-117
MAR 20 1951

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

02392

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Armadost Nursing Home Sherwood + Register Aves.</u>		STREET ADDRESS (If rural, give location) <u>3 Allegheny Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>BEULAH</u>	(Middle) <u>-</u>	(Last) <u>SOURIS</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>80 app.</u> yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. James George - Towson, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
334x Immediate cause (a) <u>Apoplexy</u>			<u>Sudden</u>
Antecedent cause(s) (b) <u>Arteriosclerosis + Hypertension</u>			<u>sub.</u>
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>left</u> 19 <u>41</u> , to <u>March 19, 1951</u> , that I last saw the deceased alive on <u>March 19, 1951</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>John F. Greene M.D. - Towson - Md</u>		DATE SIGNED <u>3/26/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 28, 1951</u>	<u>Greek Orthodox Cem.</u>	<u>Woodlawn, Balto Co., Md.</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/20/51</u>	<u>R.W. Hedrick</u>	<u>John Burns' Sons,</u>	<u>Towson, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02390

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cockeysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>		STREET ADDRESS (If rural, give location) <u>3711 Haynard Ave</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>Miss Ella Collins Spedden</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>March 9 1957</u>	(Month) (Day) (Year)
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Mar. 21-1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	9. AGE last birthday <u>55</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md</u>	
13. FATHER'S NAME <u>Hugh B. Spedden</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Spedden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Laura M. Schroeder</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
450.10 Immediate cause (a) <u>Heart Failure due to</u>		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Generalized Arteriosclerosis</u> (c)	
97 Antecedent cause(s)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec, 1947, to Mar 8, 1957, that I last saw the deceased alive on Mar 8, 1957, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter T. KeesM.D.Cockeysville Md3/9/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>3/12/57</u>	<u>3/12/57</u>	<u>St. Olaf Cemetery</u>	<u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/9/57</u>	<u>Laura M. Schroeder</u>	<u>Wm. Cook</u>	<u>St. Paul + Preston St</u>	

093888

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Reg. Dist. No.....

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

02393

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Watersedge, Dundalk 22nd</u> (If outside city or town limits write RURAL and give nearest town) How long in above place of death?..... <u>5 years</u> Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Watersedge, Balto 22nd</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>8138 Bullneck Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war..... <u>NO</u>		
3. (a) FULL NAME <u>Pauline Stelmack</u>			3. (b) Social Security Number		
4. Sex <u>F</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Widow</u>			
6. (b) Name of husband or wife <u>Casimir Stelmack</u>					
7. Birth date of deceased (mo., day, yr.) <u>MARCH 15, 1896</u>					
8. AGE: Years <u>54 yrs</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.					
9. Birthplace <u>Poland</u> (Town, county, and state)					
10. Usual occupation <u>Housewife</u>					
11. Industry or business <u>Home</u>					
MOTHER	12. Name <u>GALEZNIAK</u>				
	13. Birthplace				
FATHER	14. Maiden name <u>UNKNOWN</u>				
	15. Birthplace				
16. Informant <u>RAYMOND STELMACK</u> Address <u>8138 BULLNECK RD.</u>					
17. Burial (Burial, cremation, or removal. Which?) <u>BURIAL</u> Date thereof _____ (month) (day) (year) Cemetery or crematory <u>ST. PETER'S & PAUL'S</u> Location <u>SUMMIT HILL RD.</u>					
18. Funeral director <u>U. L. RICH & SONS</u> Address <u>2112 DUNDALK AVE. DUNDALK 22ND</u>					
19. March 8, 1951 (Date rec'd by registrar) <u>William M. Kelly, Jr.</u> Registrar					
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>March 8th 1951</u> at <u>6:30 P.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 6th 1951</u> to <u>March 8th 1951</u> and that I last saw her alive on <u>March 8th 1951</u> . Immediate cause of death <u>Coronary Occlusion</u> DURATION <u>1 Hour</u> Due to..... Due to..... Other conditions <u>470.1</u> <u>940</u> (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of Injury..... Injured at work? 23. SIGNATURE <u>Dr. Thomas M.D.</u> <u>10701 Main St.</u> <u>Dundalk 22nd</u> Address..... Date signed <u>3/8/51</u>					

RECEIVED
MAR 10 1951
BUREAU V. S.

Continued

AUT 25 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1502 Presstman Street</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) (Middle) <u>(NMI)</u> (Last) <u>STROUD</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/8/15</u>
9. AGE last birthday <u>35</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) <u>Chester, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ben</u>		14. MOTHER'S MAIDEN NAME <u>Emma Archer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cirrhosis of liver

INTERVAL BETWEEN ONSET AND DEATH

Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) None

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that VA attended the deceased from March 15, 1951, to March 15, 1951, that the deceaseddied, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

<u>Irving Freeman</u> IRVING FREEMAN, M.D., ACTING CHIEF MEDICAL SERVICE, VAH, FORT HOWARD, MD.	<u>3/16/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>March 17-1951</u>
NAME OF CEMETERY OR CREMATORY <u>York Cemetery</u>	LOCATION (City, town, or county) <u>Charlotte, N.C.</u>
DATE REC'D BY LOCAL REG. <u>March 17-1951</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>
24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave. Balto. Md.</u>	ADDRESS <u>Balto. Md.</u>

SHIP TO:

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02394

740849

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02395

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Catonsville</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>Catonsville</u> STREET ADDRESS <u>#1 - Fairview Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>—</u> (Middle) <u>Thomas</u> (Last)		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 4 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. _____	
17. INFORMANT <u>Sarah Wade</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Mitral Insufficiency</u>		<u>36 days</u>
Antecedent cause(s) (b) <u>Arterio-sclerosis</u>		<u>P.</u>
(c) _____		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) _____ SUICIDE _____ HOMICIDE _____	PLACE (Home, farm, factory, street, OF office hldg., etc.) _____ INJURY _____	(CITY OR TOWN) _____ (COUNTY) _____ (STATE) _____
TIME (Month) (Day) (Year) (Hour) _____ OF INJURY _____	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 2-12-, 1951, to 3-20-, 1951, that I last saw the deceased alive on 3-20-, 1951, and that death occurred at 1:45 A. m., from the causes and on the date stated above.

SIGNATURE C. J. Maloney (Degree or title) MD ADDRESS 57 Weyters Lane Balto 28 DATE SIGNED 3/20/51

23. BURIAL OR CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>3/23/51</u>	NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>	LOCATION (City, town, or county) _____ (State) _____
DATE REC'D BY LOCAL REG. <u>3/22/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedecie</u>	24. FUNERAL DIRECTOR <u>A. A. Balstead</u>	ADDRESS <u>Blund Hill ave. 978246</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02396

Reg. Dist. No. 338

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural near Parkton</u>	
TOWN <u>Parkton</u> LENGTH OF STAY (in this place) <u>68 yrs.</u>		TOWN <u>Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Carmel</u>		STREET ADDRESS (If rural, give location) <u>Mt. Carmel</u>	
3. NAME OF DECEASED (Type or Print) <u>William Stanley Thompson</u>		4. DATE OF DEATH <u>March 11, 1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 14, 1882</u>	
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year: Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Polisher</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Shoe making</u>	
11c. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. William Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-8163</u>	
17. INFORMANT AND ADDRESS <u>Mrs. William Thompson, Parkton, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral vascular accident

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

(b)

Generalized and cerebral arteriosclerosisSeveral years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July, 1950, to March, 1957, that I last saw the deceasedalive on 11 March, 1951, and that death occurred at 3:15 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter T. KeesM.D.Cockeysville, Ind.11 March 1951

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/12/51</u>	<u>Mt. Carmel Cem.</u>	<u>Parkton</u>	<u>Md. R.D.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/12/51</u>	<u>Chester L. Preston</u>	<u>J. Jacob Hartenstein</u>	<u>New Freedom, Penna.</u>	

690 346 Penna.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 21 1951
BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Fort Howard,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>1002 Brentwood Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILBERT</u>	(Middle) <u>R.</u>	(Last) <u>TRAUTVETTER</u>
4. DATE OF DEATH	(Month) <u>Mar.</u>	(Day) <u>24</u>	(Year) <u>19 51</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-6-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crown Cork & Seal</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pittsburgh Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clark L. Trautvetter</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Campbell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>unknown</u>	
17. INFORMANT AND ADDRESS <u>Clinical Rec. Vets. Adm. Hosp. Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Infarction of the myocardium due to arteriosclerotic coronary thrombosis</u>	<u>6 wks.</u>
Antecedent cause(s) (b) <u>Cerebrovascular accident emboli</u>	<u>5 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes Mellitus</u>	<u>unknown</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar. 1, 1951, to Mar. 24, 1951, that I last saw the deceased alive on Mar. 10, and that death occurred at 2:40 P.m., from the causes and on the date stated above.

SIGNATURE P.S. STONESIFER (Degree or title) ADDRESS M.D. VAH FORT HOWARD, MD. DATE SIGNED 3-25-51

23. BURIAL CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Union Dale Cemetery</u>	LOCATION (City, town, or county) (State) <u>Pittsburgh Pa.</u>
DATE REC'D BY LOCAL REG. <u>Mar 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Dr. H. Hedlund</u>	24. FUNERAL DIRECTOR <u>Bligh Funeral Home</u>	ADDRESS <u>6009 Harford Rd.</u>

on M. J. Bligh 763 346

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02398

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balt0.	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Laurel Hill Lane		STREET ADDRESS (If rural, give location) Laurel Hill Lane	
3. NAME OF DECEASED (Type or Print)	(First) Anna (Middle) Vierengel (Last)	4. DATE OF DEATH	(Month) March (Day) 2/51 (Year) 19
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Sept. 6, 1894--56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Frank Vierengel		14. MOTHER'S MAIDEN NAME Veronica Dauber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT AND ADDRESS Frank Vierengel, Brother, Catonsville	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinomatosis

Antecedent cause(s)

(b)

Carcinoma of uterus

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

April 1950
" "

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from **April**, 19**50**, to **March**, 19**51**, that I last saw the deceasedalive on **3/2**, 19**51**, and that death occurred at **9:15 A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/4/51**V. E. Harry****Harry A. Witte****4101 Edmondson A**

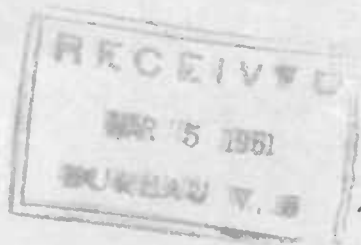
ve.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Lbr. Alagia



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

02399

in 18 shown on:

CERTIFICATE OF DEATH

FILE No. G 132 APR 13 1951 FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Relay Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Sanatorium</u>		STREET ADDRESS (If rural, give location) <u>36 Charlestown Place 18</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>R</u> (Last) <u>Drumhale</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-25-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. FATHER'S NAME <u>Harry K Drumhale</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Sally Smith</u>		14. BIRTHPLACE (State or foreign country) <u>Phila Pa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>Wife Carrie M. Drumhale</u>	
17. INFORMANT AND ADDRESS			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary thrombosis</u>			
Antecedent cause(s) (b) <u>Poisoning with Chloral Hydrate</u>			
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>due to overdose or continuous use (4/13/51 akc)</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <u>Dr. M. Kieffer M.D.</u>		ADDRESS <u>1010 Leeds on Md 30-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/2/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mt</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE RECD BY LOCAL REG. <u>4/2/51</u>		REGISTER'S SIGNATURE <u>R W Redner</u>	
24. FUNERAL DIRECTOR <u>Stewart Morris</u>		ADDRESS <u>Baltimore Md</u>	

007VUU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02400

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Milford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Milford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7308 Liberty Hights Ave</u>		STREET ADDRESS (If rural, give location) <u>7308 Liberty Heights Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Almira P. Waskey</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>24</u> , (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/29/1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>? Kohlman</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Nelle Murray 705 4th, NW Wash.DC</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Coronary Occlusion</u>	<u>15 Min</u>
Antecedent cause(s)	(b) <u>Cardio Vascular Disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/1951, to 3/24/1951, that I last saw the deceased alive on 3/23/1951, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE Wm. E. Martin, M.D. Randallstown ADDRESS Md. 3/25/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>3/28/51</u>	<u>Loudon Park</u>	<u>Baltimore Md.</u>	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 3/25/51 Wm. E. Martin 24. FUNERAL DIRECTOR John T. Stansbury ADDRESS 2700 Edmondson Av.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

negative



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 131 MAR 22 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH COUNTY <u>Baltimore</u> STATE <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vets. Adm. Hosp. Ft. Howard, Md.</u>		STREET ADDRESS (If rural, give location) <u>205 Harding Ave.</u>	
3. NAME OF DECEASED (First) <u>MARSHALL</u> (Middle) <u>W.</u> (Last) <u>WEAVER</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>4</u> (Year) <u>19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-25-95</u>
9. AGE last birthday <u>55</u> yrs.		10. If under 1 year Months Days Hours Mtn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Houghton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes - 1 WW-2</u>		16. SOCIAL SECURITY No. <u>212-16-5490</u>	
17. INFORMANT AND ADDRESS <u>Clinical Records Vets. Adm. Hosp. Ft. Howard Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of stomach</u>			<u>2 mos.</u>
Antecedent cause(s) (b) <u>151X</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last			
(c) <u>462</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT, SUICIDE, HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-16</u> , 19 <u>51</u> , to <u>3-4</u> , 19 <u>51</u> , that I last saw the deceased <u>alive on</u> , 19 <u>51</u> , and that death occurred at <u>12:35 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Samuel R. Pines</u>		ADDRESS <u>VAH FT. HOWARD, MD.</u>	
DATE SIGNED <u>3-4-51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/7/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>5806 Harford Rd. Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd. Balto</u>	

690346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

02402

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pikesville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pikesville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hooks Lane & Reisterstown Rd.		STREET ADDRESS (If rural, give location) Hooks Lane & Reisterstown Rd.	
3. NAME OF DECEASED (First) Beulah	(Middle) G.	(Last) Weber	4. DATE OF DEATH (Month) Mch. (Day) 22 (Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec 5 1886
9. AGE last birthday 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Her Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph L. Booze	
14. MOTHER'S MAIDEN NAME Mary M. Logan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Mrs. Cecelia M. Evans-(sister-in-law)	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary artery disease			1 wk.
Antecedent cause(s) (b) Cardiac Decompensation			1 yr.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		PLACE (Home, farm, factory, street, OF office bldg., etc.) None	
TIME (Month) (Day) (Year) (Hour) OF INJURY none		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? not an injury	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE D.D. Caples Dep. Med. Exam.		DATE SIGNED 3-22-'51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 3/24/51	
NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REG. March 24 1951		REGISTRAR'S SIGNATURE R.W.	
24. FUNERAL DIRECTOR Wm. J. Sicker & Sons - Balto.		ADDRESS md	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

02403

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 29	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hospital		STREET ADDRESS (If rural, give location) 613 Woodington Road	
3. NAME OF DECEASED (Type or Print) JOHN E. WEBB		4. DATE OF DEATH (Month) March (Day) 2 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3-11-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. R. Conductor		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	9. AGE last birthday 50 yrs. If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Webb		14. MOTHER'S MAIDEN NAME Laura Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dated of service) Yes WW I		16. SOCIAL SECURITY NO. 705-09-2810	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **BRONCHOGENIC CARCINOMA OF LEFT BRONCHUS WITH METASTASES TO LEFT LUNG, BRONCHIAL, TRACHEAL, AND CERVICAL LYMPH NODES, LIVER AND SPILEN**

(b) **AND CERVICAL LYMPH NODES, LIVER AND SPILEN**

INTERVAL BETWEEN ONSET AND DEATH

9 months +II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that **VA** attended the deceased from **July 17, 1950**, to **Mar. 2, 1951**.

XXXXXXXXXXXXXXXXXXXX and that death occurred at **10:10 P.** m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

ALBERT E. PUGH, M. D., VETERANS ADMINISTRATION HOSPITAL, FORT HOWARD, MD. 3-3-51

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE TIME OF Mar 6, 1951	NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG. 3/5/51	REGISTRAR'S SIGNATURE G. W. Hedrick	24. FUNERAL DIRECTOR Howard Blight Funeral Home	ADDRESS 6009 Harford Rd., Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02404

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>506 Highland Avenue</u>		STREET ADDRESS (If rural, give location) <u>506 Highland Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>FLORENCE</u> (First) <u>CORDELIA</u> (Middle) <u>WHITAKER</u> (Last)		4. DATE OF DEATH <u>Mar. 30,</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 25, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Hook</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Herbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. John S. Held, 405 Central Ave. Towson, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

15 minutes

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute cardiac failure2 hours(c) Rheumatic heart diseaseyears.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Generalized arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 30, 1951, to Mar 30, 1951, that I last saw the deceasedalive on Mar 30, 1951, and that death occurred at 4:55 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Donald L. Sonerville, M.D. 25 W. Penna. Ave, Towson 4, Md. March 30, 195123. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial April 2, 1951 Prospect Hill Cem. Towson, Md. 4/2/51 A W Hedrick JOHN BURNS SONS, Towson, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 48

02405

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dundalk Md</u>		STREET ADDRESS (If rural, give location) <u>Dundalk</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/7/1950</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday yrs. <u>6</u> If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mathew White</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alvery</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mathew White Stanbury Rd Ront 45</u>			

18. MEDICAL CERTIFICATION <u>Dundalk Md</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 mi Dist</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Congenital Hydrocephalus</u>		
(b) <u>Immediate cause</u>		
(c) <u>Antecedent cause(s)</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Dr. W. H. Redick</u>		DATE SIGNED <u>3/26/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/27/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>Brooklyn Md</u>	
DATE REC'D BY LOCAL REG. <u>3/27/51</u>		FUNERAL DIRECTOR <u>Choy O. Wilson 1000 Bristly an</u>	

209070 338375

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

418963

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vet. Adm. Hospital</u>		STREET ADDRESS (If rural, give location) <u>1018 Rosedale Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ROBERT S. WHITMORE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 5 19 51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-26-91</u>
9. AGE last birthday <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water dept. Foreman</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Whitmore</u>		14. MOTHER'S MAIDEN NAME <u>Alice Springer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Immediate cause</u> <u>Peritonitis</u>		<u>1 month</u>	
(b) <u>Antecedent cause(s)</u> <u>Perforated Gastric Ulcer</u>		<u>unknown</u>	
(c) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 3</u> , 19 <u>51</u> , to <u>March 5</u> , 19 <u>51</u> , that I saw the deceased and that death occurred at <u>3:35 Pm.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. Alfred Gakenheimer</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>3-5-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-8-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>3/7/57</u>		REGISTRAR'S SIGNATURE <u>AW Hedrick</u>	
24. FUNERAL DIRECTOR <u>Howard G. Strong</u>		ADDRESS <u>3207 W. North Ave., Balto. Md.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

523-936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in 18 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural (Catonsville)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hollywood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>- -</u>	
3. NAME OF DECEASED (Type or Print) <u>NEOMA</u> (First) <u>WILKINSON</u> (Middle) (Last)		4. DATE OF DEATH <u>March 13 1951</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 17, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private duty</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months <u>6</u> Days <u>23</u> If under 24 hrs. Hours <u>-</u> Min. <u>-</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William T. Wilkinson</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Irving G. Hart, 104 Melvin Ave</u>		18. MEDICAL CERTIFICATION <u>Baltimore 28</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypostatic pneumonia, terminal

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Inanition, dehydration, general debility

4 mos.

(c) Generalized arteriosclerosis with psychosis (4/2/51 akc)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Paranoid schizophrenia

40 yrs.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

none

none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 17, 1948, to March 13, 1951, that I last saw the deceased

alive on Mar. 13, 1951, and that death occurred at 6:23 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/14/51

Carroll

Jos. C. Mathisley

781 836

A. W. Sedick wa

Leonard

781 836

RECEIVED
MAR 16 1961
ST. LOUIS A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02408 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 Dunkirk Rd.</u>		STREET ADDRESS (If rural, give location) <u>200 Dunkirk Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>Douglas</u>	(Last) <u>Winter</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-16-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Businessman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles D. Winter</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Wells</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>186-10-0959</u>	
17. INFORMANT AND ADDRESS <u>Mr. Charles D. Winter Jr.</u>		<u>Same</u>	

J. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardio-Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

21 1/2 Yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1-49, 19....., to 3-27....., 1951, that I last saw the deceasedalive on 3-27....., 1951, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

H.W. Jenkins & Sons Co. 4905 York Rd.Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *4X*

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fort Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Vet. Adm. Hospital		STREET ADDRESS (If rural, give location) 733 W. Saratoga Street	
3. NAME OF DECEASED (Type or Print) (First) CIARENCE (Middle) (NMI) (Last) WOODFORK		4. DATE OF DEATH (Month) March (Day) 5 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married-Sep.	8. DATE OF BIRTH 3-29-99
9. AGE last birthday 51 yrs.		10. If under 1 year: Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur (retired)		10b. KIND OF BUSINESS OR INDUSTRY Law & Elec. Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Woodfork		14. MOTHER'S MAIDEN NAME Martha Scribner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 212-05-3536	
17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) RIGHT VENTRICULAR DILATATION AND HYPERTROPHY	UNKNOWN
Antecedent cause(s) (b) PULMONARY EMPHYSEMA	UNKNOWN
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DUODENAL ULCER	UNKNOWN
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that **VA** attended the deceased from **Dec. 27, 1950**, to **March 5, 1951**, that **I** last saw the deceased

XXXXXXXXXXXXXXXXXXXX and that death occurred at **10:34 A.M.**, from the causes and on the date stated above.

SIGNATURE **Paul Padget** (Degree or title) ADDRESS DATE SIGNED

PAUL PADGET, M. D., CHIEF, MEDICAL SERVICE, VAH, FORT HOWARD, MARYLAND 3-6-51

23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF Mar. 8, 1951	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) Baltimore, Maryland (State)
--	----------------------------------	---	---

DATE REC'D BY LOCAL REG. 3-7-51	REGISTRAR'S SIGNATURE A. W. Redlich	24. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Madison Avenue
--	--	--

682588 Baltimore 1, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Opitz Home Edmondson Ave. & Nunnery Lane</u>		STREET ADDRESS (If rural, give location) <u>330 Stratford Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JACOB</u> (Middle) <u>S.</u> (Last) <u>YAGLE</u>	4. DATE OF DEATH	(Month) <u>Mar.</u> (Day) <u>16,</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 6, 1858</u>
9. AGE last birthday <u>92</u> yrs.		If under 1 year	If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>George N. Yagle</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Schmidt</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mr. John C. Yagle - 330 Stratford Rd.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Respiratory failure

Antecedent cause(s)

(b) Arteriosclerotic Cardio Vascular disease

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c) Generalized Arteriosclerosis11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at			
INJURY	Work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from May, 1950, to March 17, 1951, that I last saw the deceased alive on March 1, 1951, and that death occurred at 2:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/19/51</u>	<u>Louisa Park Cem.</u>	<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/19/51</u>	<u>RW Hedrick</u>	<u>Wm. J. Lickner & Sons</u>	<u>Balto. Md.</u>	

JTV

541506

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.